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PHARMACY BRANCH

ANNUAL REPORT

serial

FISCAL YEAR 1983

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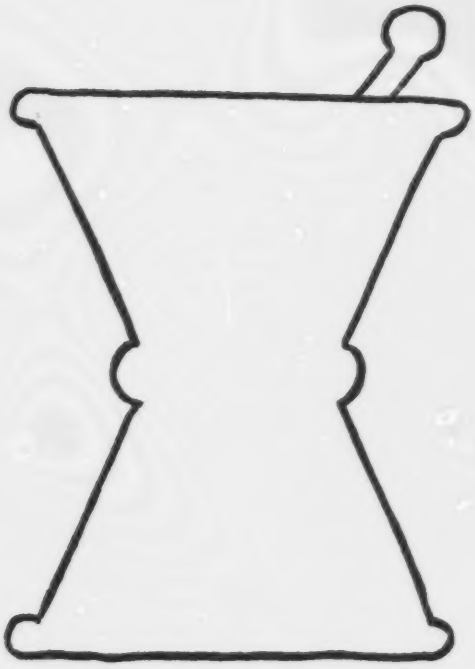

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
HEALTH RESOURCES AND SERVICES ADMINISTRATION
INDIAN HEALTH SERVICE

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FORWARD

The Annual Report for Pharmacy for FY 1983 continues to show an increase in the patient care services by pharmacists. Today, pharmacists are assigned to 111 facilities - 48 hospitals and 63 health centers.

Improvements in pharmacy care have been achieved by the development and use of standards of care for pharmacists in caring for patients with certain acute and chronic illnesses at more facilities.

During FY 1983, pharmacists were responsible for providing primary care for 473,000 ambulatory patients or 14.4 percent of the total ambulatory patients that visited the Indian Health facilities. Pharmacists in the Portland Area provided care for 32.6 percent of the outpatients, in the Bemidji Area 24.0 percent, in the Oklahoma City Area 20.4 percent and in the Aberdeen Area 20.3 percent. Pharmacy practitioners provided primary care for 35,574 ambulatory patients, 1.1 percent of the total visits.

Pharmacy workload units for FY 1983 increased .3 percent, from 6,305,000 in FY 1982 to 6,326,000 in FY 1983.

This report provides statistics on activities by pharmacists during the past year and includes comparison data to assist in the evaluation of the pharmacy program progress for each Area. Abstracts from the Area reports are also included, as well as the Minutes of the Area Pharmacy Officers' Conference which was held September 12-15, 1983 at Headquarters.

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SIGNIFICANT ACCOMPLISHMENTS
IN
PHARMACY BRANCH

Three pharmacists were detailed to Africare to evaluate the management and distribution of pharmaceuticals in The Gambia.

Headquarters branch assisted in obtaining and distributing Hepatitis-B vaccine throughout the Indian Health Service.

Mr. Theodore Westley, Chief, Area Pharmacy Branch, Aberdeen Area, developed a computerized workload compiling system now in use in most Areas of Indian Health Service. There is multiple hours in savings each quarter and year.

Developed and streamlined procedures and methods to maintain budgetary control for efficient use of drugs due to budgetary constrains.

Placed three 437 graduates in pharmacy in Indian Health Service.

Developed a pharmacy salary cost report which reflects gross pay quarterly and projects annual gross cost of pharmacy personnel in Indian Health Service.

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PHARMACY ACTIVITIES DURING FISCAL YEAR 1983

A. Program Trends

1. Primary Health Care

In that part of pharmacy services in which the pharmacist is the primary provider of health care services, the pharmacist monitors and manages ambulatory patients with chronic diseases and assesses and treats ambulatory patients with acute diseases.

As the primary provider of care, pharmacists saw 473,000 ambulatory patients in FY 1983. The 473,000 patient visits represented 14.4 percent of all ambulatory patient visits in FY 1983. (See Exhibit 1 for visits to pharmacists by Area). In the Portland Area 32.6 percent of all ambulatory patients received primary care from pharmacists, and in the Bemidji Area 24.0 percent. Visits to pharmacists for primary care by disease category are indicated on Exhibit 2.

Of the total patients visiting pharmacists for primary care 38,000 or 8.0 percent were referred to physicians. This indicates that the pharmacist is not exceeding his limitations of skills and knowledge in patient care. Of the visits for primary care, 47.1 percent were for acute diseases and 65.1 percent were for chronic diseases.

It is estimated that 41 physician man years would have been required to care for the patients seen by pharmacists.

2. Special Activities

(a) Ambulatory patients with certain acute illnesses such as coughs, skin rashes and stomach disorders elected to see the pharmacist instead of the physician at 95 of the hospitals and clinics. Of these, 88 have approved protocols or standards of care for use by the pharmacist. (See Exhibit 3).

Using established standards of care, the pharmacist obtained subjective and objective data which includes patient symptoms, vital signs and laboratory tests as indicated. The pharmacist evaluated the data and made a judgment as to whether to treat the patient himself or refer the patient to a physician.

(b) Long term drug therapy for ambulatory patients with chronic diseases was monitored by the pharmacist in 100 facilities with 97 having approved protocols or standards of care for use by the pharmacists.

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The pharmacist obtains subjective and objective data including laboratory test results when indicated. The pharmacist evaluates data to determine whether or not the disease is under control. This activity increases the time period between physician visits and reduces the physicians workload.

(c) Of the 111 facilities with pharmacists, 65 had tuberculosis followup programs managed by pharmacists to ensure compliance and adequate treatment.

(d) Sixty-three of the facilities enter the drugs prescribed by contract physicians in the patient's health record. This provides a complete drug history in the patient's record and promotes rational drug therapy and helps prevent adverse effects from drugs.

(e) Pharmacists in 46 hospitals were making patient rounds with physicians to provide assistance in rational drug therapy and prevent adverse drug effects.

(f) Pharmacy rounds for monitoring patient response to drug therapy and patient education were made at 43 hospitals.

(g) Private consultation offices were located in 72 of the pharmacies.

(h) Fifty facilities had affiliations with universities for the training of pharmacy students.

(i) Intravenous additive program services for inpatient and emergency care were provided by pharmacists at 39 hospitals. This service relieves the nurses of this activity and provides for eliminating incompatible mixtures.

(j) Unit dose distribution systems were utilized in 39 hospitals. This drug distribution system reduces medication errors, providing an efficient system for administration of the proper drug to patients and takes less nursing time.

(k) Forty-nine facilities had a functional drug information center.

(l) Pharmacists at 12 hospitals were obtaining drug histories on patients at or soon after admission to assist in appropriate drug therapy.

(m) Pharmacists at 69 facilities participated in drug utilization reviews.

(n) One hospital had a pharmacist on duty 24-hours, seven days a week.

(o) Fifty-one facilities had a pharmacist on call when the pharmacy was closed.

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(p) Thirty-two facilities had pharmacists on duty beyond the regular eight-hour day, five days a week.

(q) Twenty-nine facilities had pharmacists on duty on Saturdays.

(r) Pharmacists were assigned to 111 facilities - 48 hospitals and 63 health centers.

3. Training Programs

Thirty-four pharmacists enrolled in the home study program presented by the Clinical Support Center, Phoenix, AZ, for FY 1983.

Listed below, by Area, are the number of pharmacists who participated in the Area sponsored Continuing Education Conferences for FY-1983.

Aberdeen/Bemidji Areas - 35 pharmacists participated in the annual area conference for pharmacy continuing education receiving 10 credit hours.

Alaska Area - 6 pharmacists participated in the annual area conference for pharmacy education receiving 6 credit hours.

Albuquerque, Navajo, Phoenix and Tucson Areas - 100 pharmacists attended a multiple area conference held in Flagstaff, AZ, receiving 15 hours of continuing education credits.

Billings Area - 14 pharmacists attended an area pharmacy continuing education conference and each earned 5-1/2 credits hours.

Portland Area - 10 pharmacists attended a Clinical Support Center Seminar for non-physician primary care providers in Salem, Oregon. Each pharmacist was able to obtain 17 continuing education credits.

4. Drug Use Monitoring and Services for Indian Operated Contract Facilities

I am pleased to report that pharmacy services were provided for Indian patients at three nursing homes and one contract hospital.

5. First Visits and Revisits to Pharmacists for Primary Care (Exhibit 2)

In FY 1983 the number of first visits to pharmacists for primary care were 189,000. Revisits to pharmacists were 335,000.

6. Pharmacy Workload

Workload units for FY 1983 increased .3 percent, from 6,305,000 in FY 1982 to 6,326,000 in FY 1983.

All pharmacy activities in the Pharmacy Quarterly Report form are converted to workload units with one workload unit equivalent to eight minutes in time. (See Exhibit 4).

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7. Indian Pharmacists

I am pleased to report that 32 of our pharmacists on duty are Indians or Alaska Natives assigned to various positions throughout the Indian Health Service.

There were eight Indian students in pharmacy schools under the scholarship program. Four graduated in 1983 and three will graduate in 1984.

8. Staffing

Staffing in pharmacy positions increased slightly from 1982 to 1983. There were 270 Commissioned Corps pharmacists, 9 Civil Service pharmacists and 41 non-pharmacist positions, a total of 320. In addition, 32 pharmacists were in administrative positions at Headquarters, Areas and Service Units with responsibilities in health activities other than pharmacy.

There were seven pharmacists assigned to Indian Tribal and Alaska Native corporation operated clinics.

Pharmacy staffing was 47.5 percent of that required by the Resource Requirement Methodology (RRM) standards. Pharmacist positions were 57 percent staffed and technician/clerical positions 21.5 percent staffed. The RRM needs, on duty and unmet staffing needs, are in the following chart. If the ratio of pharmacists to population in the United States were used in IHS, one pharmacist per 1,600, the pharmacist needs would be 540 pharmacists.

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Pharmacy Personnel and Drug Costs - FY 1983
(Excluding salary costs of Area & Headquarters personnel)

1. Hospital Inpatient		
Personnel		$2,166,702
Drugs		4,219,925
	Total	$6,386,627
2. Hospital Outpatient		
Personnel		$3,808,144
Drugs		6,240,793
	Total	$10,046,937
3. Health Center Costs		
Personnel		$3,404,818
Drugs		3,847,924
	Total	6,892,742

Patient Care Drug Costs

	Drugs Only	Drugs and Personnel
1. Cost per hospital admission	$54.08	$81.85
2. Cost per inpatient day	10.38	15.72
3. Cost per outpatient visit (hospital)	3.05	5.13
4. Cost per outpatient visit (health center)	3.92	7.03

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Staff Activity	Pharmacists	Technicians & Clericals	Totals
RRM Needs			
Ambulatory Care	353	104	457
Inpatient Care	114	71	185
Area Branch Direction	11	11	22
Research & Development	1	1	2
Psychiatric Pharmacy	4	2	6
Headquarters	2	1	3
Totals	485	190	675
On Duty, 9/30/83	279	41	320
Percent Staffed	57%	21.5%	47.5%
Unmet Needs	206	149	355

Drug Costs - FY 1983

Drug costs for direct purchases and contract prescriptions were $15,492,583. A breakdown by patient cost, inpatient ambulatory, is in the chart below.

Purchases

Drug Purchases, Actual Obligation	$ 14,308,642
Contract Drug Costs	1,518,718
Total	$ 15,827,360
Number of Contract Prescriptions	116,824
Average Cost Per Contract Prescription	$13.00
Pharmacy Personnel (includes Area and Headquarters Personnel)	$ 9,974,424

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EXHIBIT 1

NUMBER OF AMBULATORY PATIENT VISITS TO PHARMACISTS AS THE PRIMARY PROVIDER OF CARE WITH PERCENTAGE OF TOTAL AMBULATORY VISITS BY AREA AND FOR THE INDIAN HEALTH SERVICE

Area	FY 1982 OPV	FY 1982 Percentage of Total	FY 1983 OPV	FY 1983 Percentage of Total
Aberdeen	77,000	19.9	82,000	20.3
Alaska	30,000	11.2	31,000	10.4
Albuquerque	28,000	10.1	29,000	10.6
Bemidji	28,000	27.0	26,000	24.0
Billings	45,000	17.1	48,000	17.8
Navajo	12,000	1.8	10,000	1.8
Oklahoma City	166,000	25.6	121,000	20.4
Phoenix	36,000	8.5	36,000	9.0
Portland	62,000	31.8	67,000	32.6
Tucson	7,000	11.7	7,000	11.6
Nashville	14,000	18.4	16,000	15.9
IHS TOTALS	505,000	15.1	473,000	14.4

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EXHIBIT 2

TOTAL VISITS, FIRST VISITS AND REVISITS
TO PHARMACISTS AS THE PRIMARY PROVIDER OF CARE
FOR FISCAL YEARS 1982 AND 1983 BY DISEASE CATEGORY

	1982	1983
Infections and Parasitic	15,200	17,000
Neoplasms	1,000	1,000
Endocrine, Nutritional & Metabolic	44,000	44,000
Blood and Blood Forming Organs	1,400	1,400
Mental Disorders	13,000	13,000
Nervous System	14,000	14,000
Eye Diseases	5,000	6,000
Ear Diseases	5,000	5,000
Circulatory System	68,000	66,000
Respiratory System	51,000	50,000
Digestive System	26,000	27,000
Urinary Tract	5,000	5,000
Male Genitalia	200	100
Female Genitalia & Breast	5,600	5,000
Pregnancy & Childbirth	4,000	3,700
Skin & Subcutaneous Tissue	23,000	22,000
Musculoskeletal System	22,000	22,000
Congenital Anomalies	200	100
Accidents, Poisoning & Violence	3,000	3,000
Symptons & Ill. Defined Conditions	34,000	33,000
Supplemental	96,000	97,000
Family Planning	26,000	26,000
Immunization	12,000	62,000
Invalid	400	700
TOTALS	475,000	524,000
Percent of Total Outpatient Visits	14%	16%
First Visits	140,000 29%	189,000 36%
Revisits	335,000 71%	335,000 64%

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EXHIBIT 3

INDIAN HEALTH SERVICE FACILITIES HAVING CERTAIN
PHARMACY SERVICES OR ACTIVITIES
FY 1983

ACTIVITY	ABER	ALBU	ANCH	BEMI	BILL	NAVA	OKLA	PHOE	PORT	TUCS	NASH	TOTALS
1. Had programs for managing chronic disease patients.	14	13	7	3	10	2	27	10	10	2	2	100
2. Had chronic disease protocols.	14	13	7	2	10	2	27	10	8	2	2	97
3. Had programs for primary care for patients with acute diseases.	14	12	7	4	11	4	22	8	10	1	2	95
4. Had acute illness protocols.	14	9	7	3	11	4	23	8	6	1	2	88
5. Had TB followup programs.	14	6	0	4	10	2	12	6	10	2	1	67
6. Entered contract care prescriptions in patients charts.	14	9	1	3	1	0	22	3	6	2	2	63
7. Made physician rounds.	5	5	6	2	3	6	5	9	NA	1	2	44
8. Made pharmacy rounds.	7	4	7	2	3	0	6	6	NA	1	2	38
9. Had consultation offices.	6	10	7	2	7	7	20	7	9	2	2	79
10. Had affiliation with pharmacy schools.	6	1	9	3	2	5	11	8	2	2	2	51
11. Had intravenous additive programs.	6	4	8	1	0	5	6	7	2	1	2	42
12. Had unit dose systems.	8	6	6	1	1	6	5	7	NA	1	2	43
13. Had functional drug information services.	14	12	2	1	0	6	14	2	0	2	2	55
14. Obtained inpatient drug histories.	3	1	3	0	1	0	2	0	NA	1	1	12
15. Participated in drug utilization reviews.	14	10	4	3	5	8	11	12	5	1	2	75

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EXHIBIT 4

PHARMACY ANNUAL AND CUMULATIVE WORKLOAD REPORT

FISCAL YEAR - 1983

FUNCTIONS	ABERDEEN	ALBUQUERQUE	ALASKA	BEMIDJI	BILLINGS	NAVAJO	OKLAHOMA	PHOENIX	PORTLAND	TUCSON **/	NASH-VILLE	IHS TOTAL WORKLOAD UNITS
I. Pharmacy Activities												
A. Inpatient Activities												
1. Prescriptions Dispensed	3,653	3,939	5,451	2,280	15,965	44,906	14,405	8,223	-	2,329	2,596	103,737
2. Unit Dose Dispensed	19,609	17,995	24,791	6,574	2,417	45,925	26,035	25,095	-	5,544	11,309	185,294
3. Stock Containers Issued	8,008	8,679	27,964	2,362	4,239	32,420	22,873	29,918	-	2,661	2,112	141,236
4. I.V. Admixtures	17,451	46,822	112,767	14,858	5	145,238	77,729	64,874	1,173	603	13,696	495,217
5. Clinical Counseling Service	2,723	3,103	6,745	2,202	950	3,206	15,143	9,569	-	-	812	44,453
6. Medication Histories	664	1,058	739	25	10	5,112	2,113	5	-	-	1,109	10,835
7. Rounds with Physician	1,711	8,036	19,165	3,774	5,966	6,349	9,457	15,321	-	-	3,725	73,504
8. Pharmacy Rounds	2,943	6,959	18,232	5,133	2,956	18,942	19,276	25,049	-	1,891	1,728	103,109
B. Outpatient Activities												
1. Prescriptions Dispensed (New and Refill)	367,585	225,912	209,647	159,968	299,563	505,324	752,890	310,778	249,371	93,099	98,994	3,273,131
2. Pharmacy Visits for Primary Care	82,155*	28,818*	31,135*	25,521*	47,775*	10,482*	120,963*	36,063*	67,072*	7,018*	15,508*	472,510*
a. Acute Diseases	43,525	15,192	7,334	15,572	22,506	5,174	58,377	13,200	32,188	3,487	6,114	222,669
b. Chronic Diseases	32,454	18,599	29,087	10,565	34,821	6,633	93,984	26,228	48,390	414	6,639	307,814
c. No. of Patients Referred to Physician	4,563	2,983	5,546	3,993	3,173	1,990	7,095	4,149	3,369	41	1,436	38,338
3. Clinical Counseling	-	49,465*	101,196*	43,344*	1,504*	-	130,923*	-	65,858*	55,624*	-	356,914*
4. Medication Histories	2,407	3,542	348	237	95	62	2,532	48	2,076	980	2,172	14,499
5. Stock Containers Issued	9,945	5,144	10,703	3,034	9,969	28,495	11,437	13,234	1,983	7,177	2,432	102,653
6. Prescriptions Dispensed by Non-Pharmacist	-	12,644*	2,285*	9,977*	22,810*	-	22,539*	-	9,489*	12,599*	-	92,343*
C. Satellite Activities												
1. Satellite Issues	11,939	10,224	43,555	14,477	5,095	12,432	2,674	12,862	4,018	7,518	11,430	136,224
2. Visits to Satellite Facilities	10,984	12,976	4,824	4,016	13,587	21,619	17,253	30,762	3,738	1,605	1,786	123,150
D. Groups Provided Clinical Counseling Service												
1. T.B.	-	-	162	-	-	-	-	-		-	-	162
2. Diabetic	47	14	-	-	712	4,236	911	103		-	1,382	7,405
3. Prenatal	-	43	-	-	4	-	380	-		-	518	1,125
4. Postnatal (Family Plan)	-	-	-	-	-	-	-	-	COMBINED 180	-	734	734
5. Mother & Well Baby	-	-	-	-	-	-	-	-		-	346	346
6. Mental Health	-	-	-	-	-	-	-	-		-	-	-
7. Other	104	120	547	-	10	-	29	124		-	-	934

PHARMACY ANNUAL AND CUMULATIVE WORKLOAD REPORT

FISCAL YEAR - 1983

FUNCTIONS	ABERDEEN	ALBUQUERQUE	ALASKA	BEMIDJI	BILLINGS	NAVAJO	OKLAHOMA	PHOENIX	PORTLAND	**/ TUCSON	NASH-VILLE	IHS TOTAL WORKLOAD UNITS
E. Groups Addressed - Community Service												
1. Students	187	131	65	864	43	1,263	338	632		-	7	3,530
2. Organization	36	65	48	342	50	173	324	7		-	-	1,045
3. General Public (Radio, TV, etc.)	74	415	115	-	-	-	90	228	COMBINED	-	7	929
4. Staff Inservice Training	629	6,797	3,786	180	950	5,676	3,772	5,039	7,376	-	913	35,118
5. Pharmacy & Therapeutics	826	2,045	1,660	465	1,029	1,717	1,715	1,502		979	336	12,274
6. Home Visits	63	43	22	4	21	472	2	226		-	-	853
7. Committee Meetings	3,331	8,831	13,403	1,859	3,968	9,577	9,642	5,013		1,537	641	57,802
II. Other Activities												
A. Laboratory	-	677*	-	6*	4*	-	241*	-	204*	-	-	1,132*
B. X-ray	-	26*	-	2*	-	-	1,467*	-	202*	-	-	1,697*
C. Supply Management	-	1,752*	-	4,849*	1,352*	-	3,391*	-	2,075*	1,670*	-	15,089*
D. Other Pharmacy Administrative Duties	-	1,800*	-	960*	916*	-	1,894*	-	788*	2,880*	-	9,238*
E. Non-Pharmacy Admin. Duties (SUD or Admin. Officers)	-	5,114*	-	54*	612*	-	3,749*	-	667*	1,440*	-	11,636*
F. Contract Charting and Utilization Review	1,840	1,615	4,968	2,031	438	334	1,816	932	3,155	-	86	17,215
G. Bulk Compounding	7,952	2,040	8,744	496	10,088	40,048	4,696	37,352	2,425	8,032	912	122,785
H. Prepackaging	25,419	6,240	16,251	12,477	3,588	52,413	38,048	41,620	3,579	11,899	17,827	229,361
I. Pharmacy Audit or Peer Review	1,655	7,161	2,096	468	3,040	5,402	5,117	2,891	621	-	1,618	30,069
J. Drug Information Service	2,872	4,599	4,237	1,308	2,874	4,341	9,221	14,158	1,831	173	722	46,336
K. Staff Consultation	3,340	8,844	7,205	3,059	3,324	5,959	9,994	4,726	6,202	202	849	53,704
L. Teaching	2,911	2,053	7,340	1,495	201	4,989	2,328	1,714	1,224	113	2,472	26,840
M. Additional Activities	4,989	31,970	40,447	25,613	3,984	17,230	85,784	42,815	1,111	907	46,461	301,311
III. TOTALS	596,439	474,180	637,994	299,731	455,641	1,037,657	1,307,480	748,397	373,110	151,191	243,921	6,325,741

*/ No workload conversion factor given and are not included in the Total Workload Units.

**/ Tucson Area includes Sells & San Xavier Service Units.

PHARMACY ANNUAL AND CUMULATIVE WORKLOAD REPORT

FISCAL YEAR - 1983

FUNCTIONS	ABERDEEN	ALBUQUERQUE	ALASKA	BEMIDJI	BILLINGS	NAVAJO	OKLAHOMA	PHOENIX	PORTLAND	TUCSON **/	NASH-VILLE
IV. Medication Cost Data (Cumulative)											
A. Hospital Inpatient											
Admissions	-	5,396	10,110	-	3,939	-	15,364	-	-	1,287	-
Total Cost	$820,715	$205,759	$416,450	$113,308	$216,645	$964,342	$795,794	$428,455	-	$99,903	$158,554
Cost Per Admission	-	$38.13	$41.19	-	$55.00	-	$51.80	-	-	$77.62	-
B. Hospital Outpatient											
Outpatient Visits	-	167,201	207,144	-	114,783	-	328,321	-	-	23,332	-
Total Cost	$561,263	$439,884	$736,982	$291,362	$393,752	$1,334,151	$1,237,234	$844,092	-	$91,410	$310,663
Cost Per Outpatient Visit	-	$2.63	$3.56	-	$3.43	-	$3.77	-	-	$3.60	-
C. Field Health Outpatient											
Outpatient Visits	-	105,643	62,529	-	139,863	-	299,118	-	207,688	16,156	-
Total Cost	$383,000	$390,886	$161,899	$234,332	$397,107	$255,700	$1,127,186	$108,211	$661,341	$49,922	$78,340
Cost Per Outpatient Visit	-	$3.70	$2.59	-	$2.84	-	$3.77	-	$3.18	$3.09	-
D. Contract Prescriptions											
No. of Prescriptions	3,347	521	6,366	18,195	15,814	-	899	14,239	53,919	-	1,796
Total Cost	$25,052	$7,319	$66,587	$189,941	$228,333	-	$14,975	$183,108	$639,431	-	$14,892
Cost Per Prescription	$7.48	$14.05	$10.46	$10.44	$14.44	-	$16.66	$12.86	$11.86	-	-

The above figures were submitted through the Quarterly Pharmacy Report by the Area Branch Chiefs.

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PHARMACY WORKLOAD UNITS BY AREA
FISCAL YEARS 1982 AND 1983

Area	1982	1983
Aberdeen	748,325	596,439
Alaska	578,347	637,994
Albuquerque	474,679	474,180
Bemidji	246,671	299,731
Billings	448,731	455,641
Navajo	982,834	1,037,657
Oklahoma	1,410,921	1,307,480
Phoenix	777,899	748,397
Portland	335,800	373,110
Tucson	106,361	151,191
Nashville	193,959	243,921
TOTALS	6,304,527	6,325,741

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COMPARISON OF INPATIENT AND OUTPATIENT ACTIVITIES

FY-1973 TO FY-1983

Fiscal Year	Inpatient No. Prescriptions Dispensed	Outpatient No. Prescriptions Dispensed */
1983	103,737	3,273,131
1982	121,338	3,385,252
1981	136,174	3,545,686
1980	121,921	2,963,269
1979	116,100	3,044,300
1978	128,377	2,973,925
1977	54,332	1,829,223
1976	110,550	2,447,483
1975	111,640	2,052,324
1974	116,411	1,863,219
1973	63,515	1,958,592

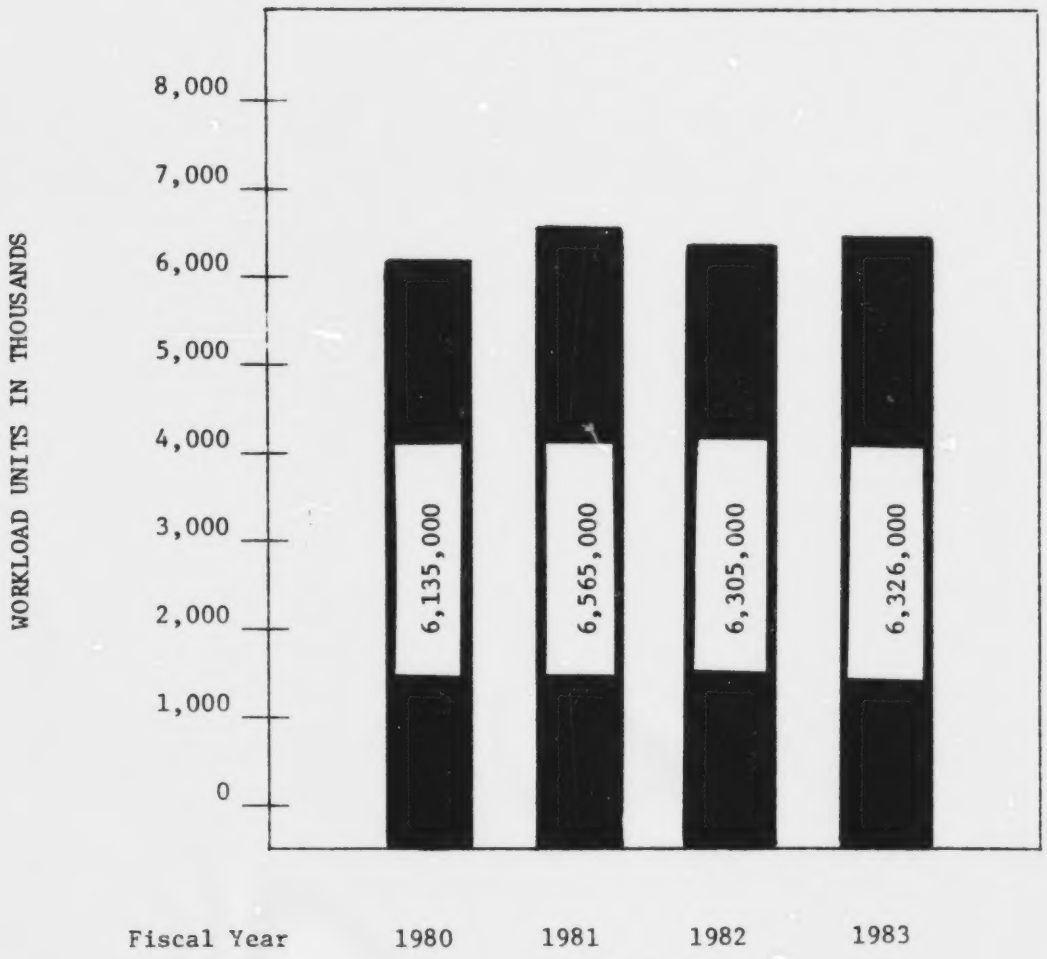
*/ New and Refill

COMPARISON OF

PHARMACY WORKLOAD UNITS */ PERFORMED AT

IHS HOSPITAL AND HEALTH CENTER PHARMACIES

FISCAL YEARS 1980 - 1983



*/ One pharmacy workload unit is equivalent to the average time required to fill one prescription.

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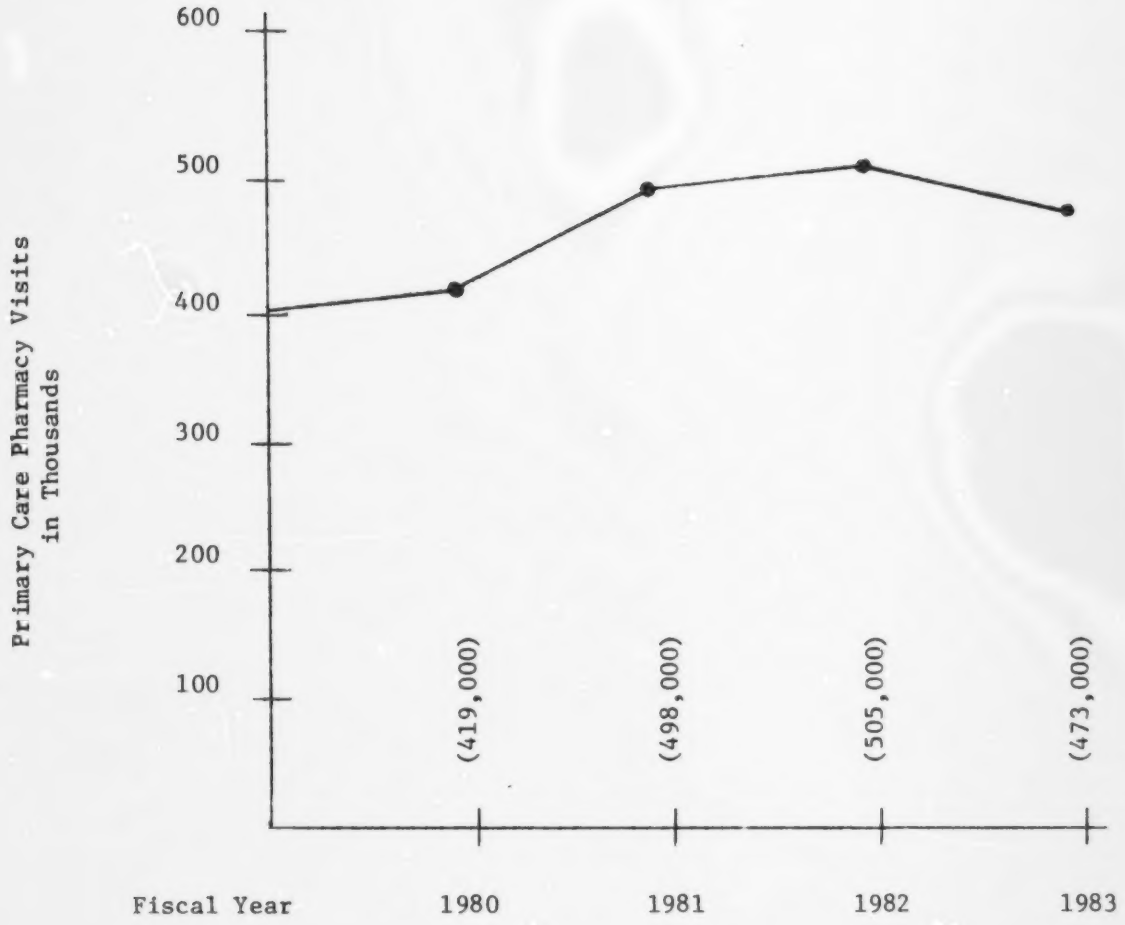
COMPARISON OF
AMBULATORY PRIMARY CARE VISITS TO PHARMACISTS



Includes patients with acute and chronic diseases whose primary encounter was with a pharmacist. Does not include secondary patient encounters such as those who visited a physician first.

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AMBULATORY PATIENT CARE
TOTAL OUTPATIENT, PHARMACIST AND PHARMACIST PRACTITIONER VISITS */
BY AREA AND SERVICE UNIT
FY-1983

Area/Service Unit	Total Visits	Pharmacist Visits	Percent of Total	Pharmacist Practitioner Visits	Percent of Total
Total, All Areas	3,252,701	432,818	13.3	35,574	1.1
ABERDEEN AREA	411,928	82,143	19.9	12	.0
Rapid City	36,512	4,129	11.3	--	--
Cheyenne River	36,341	4,820	13.3	1	.0
Fort Berthold	17,357	2,621	15.1	--	--
Fort Totten	21,021	4,236	20.2	--	--
Pierre	18,566	4,552	24.5	--	--
Pine Ridge	64,356	9,666	15.0	4	.0
Rosebud	37,858	8,787	25.2	3	.0
Sisseton-Wahpeton	36,648	6,592	18.0	2	.0
Standing Rock	39,258	10,019	25.5	1	.0
Turtle Mountain	56,652	15,028	26.5	--	--
Omaha-Winnebago	22,956	6,453	28.1	1	.0
Yankton	24,393	5,240	21.5	--	--
Unspecified	10	--	--	--	--
ALASKA AREA	259,227	26,368	10.2	629	.2
Anchorage	99,582	4,701	4.7	8	.0
Annette Island	7,510	2	.0	--	--
Barrow	18,847	1,523	8.1	2	.0
Kotzebue	19,667	999	5.1	4	.0
Mt. Edgecumbe	36,724	4,690	12.8	614	1.7
Interior Alaska	31,014	8,557	27.6	--	--
Yukon-Kuskokwim-Delta	45,883	5,896	12.9	1	.0

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Area/Service Unit	Total Visits	Pharmacist Visits	Percent of Total	Pharmacist Practitioner Visits	Percent of Total
ALBUQUERQUE AREA	273,681	20,889	7.6	7,921	2.9
Albuquerque	78,929	7,742	9.8	43	.1
Acoma-Canoncito-Laguna	40,461	2,945	7.3	--	--
Mescalero	21,643	2,493	11.5	1	.0
Santa Fe	75,635	6,392	8.5	2,367	3.1
Zuni-Ramah	35,504	1,136	3.2	--	--
Southern Colorado	20,907	140	.7	5,510	26.4
Unspecified	602	41	6.8	--	--
BEMIDJI PROGRAM AREA	106,135	24,736	23.3	785	.7
Eastern Michigan	14,346	4,512	31.5	35	.2
Greater Leech Lake	26,637	4,680	17.6	71	.3
Red Lake	40,803	6,788	16.6	--	--
White Earth	24,347	8,756	36.0	679	2.8
Unspecified	2	--	--	--	--
BILLINGS AREA	268,768	45,890	17.1	1,885	.7
Intermountain	12,656	18	.1	--	--
Blackfeet	47,081	6,524	13.9	1,679	3.6
Crow	44,821	7,286	16.3	2	.0
Flathead	1,466	--	--	--	--
Fort Belknap	22,881	3,875	16.9	57	.2
Fort Peck	45,928	10,239	22.3	146	.3
Wind River	48,171	10,100	21.0	--	--
Northern Cheyenne	29,022	3,851	13.3	--	--
Rocky Boy's	16,742	3,997	23.9	1	.0

Area/Service Unit	Total Visits	Pharmacist Visits	Percent of Total	Pharmacist Practitioner Visits	Percent of Total
NASHVILLE PROGRAM	83,857	10,364	12.4	5,144	6.1
Cherokee	53,073	9,117	17.2	5,141	9.7
Choctaw	30,784	1,247	4.1	3	.0
NAVAJO AREA	586,752	9,503	1.6	1,007	.2
Chinle	71,740	1,058	1.5	7	.0
Crownpoint	35,923	711	2.0	--	--
Ft. Defiance	71,481	1,286	1.8	4	.0
Gallup	133,992	1,976	1.5	12	.0
Kayenta	51,666	700	1.4	3	.0
Shiprock	86,146	2,434	2.8	59	.1
Tuba City	97,053	1,283	1.3	2	.0
Winslow	36,991	12	.0	914	2.5
Unspecified	1,760	43	2.4	6	.3
OKLAHOMA AREA	593,131	114,268	19.3	6,695	1.1
Ada	94,614	16,397	17.3	247	.3
Claremore	137,287	22,755	16.6	2,264	1.6
Clinton	25,069	8,221	32.8	270	1.1
Kansas	17,795	3,857	21.7	--	--
Lawton	73,048	16,040	22.0	415	.6
Pawnee	45,807	13,754	30.0	--	--
Shawnee	31,782	6,820	21.5	1	.0
Tahlequah	104,566	18,832	18.0	--	--
Talihina	63,163	7,592	12.0	3,498	5.5

Area/Service Unit	Total Visits	Pharmacist Visits	Percent of Total	Pharmacist Practitioner Visits	Percent of Total
PHOENIX AREA	402,717	29,205	7.3	6,858	1.7
Unitah-Ouray	11,885	993	8.4	--	--
Keams Canyon	37,274	182	.5	51	.1
Owyhee	10,805	1,556	14.4	15	.1
Colorado River	34,487	2,895	8.4	68	.2
Phoenix	124,193	3,338	2.7	3,293	2.7
Sacaton	36,713	3,625	9.9	1,420	3.9
San Carlos	45,183	5,320	11.8	3	.0
Schurz	15,298	1,520	9.9	14	.1
Whiteriver	62,989	2,838	4.5	1,359	2.2
Fort Yuma	23,478	6,917	29.5	630	2.7
Unspecified	412	21	5.1	5	1.2
PORTLAND AREA	206,028	65,255	31.7	1,817	.9
Colville	21,702	2,602	12.0	1	.0
Ft. Hall	28,102	11,680	41.6	6	.0
Neah Bay	13,147	3,170	24.1	--	--
Northwest Washington	17,092	6,358	37.2	3	.0
Northern Idaho	14,013	4,837	34.5	--	--
Taholah	11,491	3,010	26.2	1	.0
Umatilla	12,855	4,507	35.1	1	.0
Warm Springs	19,861	5,680	28.6	--	--
Wellpinit	14,236	3,368	23.7	--	--
Yakima	41,142	16,266	39.5	--	--
Western Oregon	12,373	3,777	30.5	1,805	14.6
Unspecified	14	-	--	--	--
TUCSON PROGRAM AREA	60,477	4,197	6.9	2,821	4.7
Sells	60,477	4,197	6.9	2,821	4.7

*/ Figures obtained from Office of Program Statistics, Ambulatory Care Branch, IHS (1A Report - September 1983)

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PHARMACIST PRACTITIONERS (PP's) **/

(Includes Trainees & Area Office Pharmacists Trained as PP's)

Area	Total
Aberdeen	2
Alaska	5
Albuquerque	7
Bemidji	3
Billings	5
Navajo	6
Oklahoma	11
Phoenix	13 */
Portland	6
Tucson	1
Nashville	1
Total	60

*/ Phoenix Area - CCEC (2) listed.

**/ Program discontinued May 1981.

Five (5) pharmacists took training but are now separated.

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ABERDEEN AREA

Area Highlights

Aberdeen (Ted Pukas)

During the first quarter of the year, pharmacy audits were done in conjunction with Medicare/Medicaid presurveys. At the Rosebud, Sisseton, Wagner and Fort Yates Hospitals and the McLaughlin Health Center.

Rosebud: Unit-dose program initiated and working smoothly. Pharmacy active in provision of inservice programs regarding emergency room medicine and proper use/techniques involving the laminar flow hood.

Sisseton: Workload is very high for a one pharmacist station. Weekly pharmacy service to the community nursing home continues. Pharmacist not able to use his primary care abilities because of the need for his traditional service.

Wagner: Chief Pharmacist highly involved with the Hospital Safety Committee. Difficulties in obtaining supplies due to local problems is evident.

Ft. Yates: Temporary nature of the medical staff at this facility has created an inefficient health delivery program. Improvements in the unit-dose system have been made, i.e. greater turnover of strip-packaged medicines due to more frequent packaging assuring a higher quality product. Department space expansion has been approved.

McLaughlin: Medical staffing deficiencies have affected the operation of this clinic also. Increased working space for this pharmacy has also been approved.

Two drug utilization reviews are being started in Rapid City. One will review the need for potassium supplements in patients taking Dyazide. The other study will review patient compliance/confusion in people taking eight or more drugs. The results of these reviews should be of interest to all.

A very successful spring pharmacy officers seminar was held in Aberdeen during April. We are very appreciative of the teaching support we received from the IHS hospital, Whiteriver, Arizona.

Belcourt (Douglas DeMontigny)

We have gradually but steadily increased from a quarterly outpatient prescription volume of 13,000 in 1980 to our present level of nearly 20,000 prescriptions per quarter.

The Belcourt pharmacy has been expanded physically - providing much needed working area. Baker cells have also been installed to facilitate outpatient dispensing.

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Eagle Butte (Fred G. Paavola)

The Eagle Butte unit dose program is being expanded beyond oral solid dosage forms. The pharmacy will also be working with a local nursing home to attempt to supply OTC products for the Indian residents.

Mr. Paavola has been requested to chair the Advisory Working Group on Administrative Pharmacy for 1 to 100 beds for the American Society of Hospital Pharmacists.

Ft. Yates (Gordon Johnston)

The pharmacy reinstituted a tuberculosis patient profile. Records on treatment progress, refills and follow-up were inconsistent. It was difficult to determine treatment status of many of our patients. The profile should aid in monitoring lab values, chest exams, medications and compliance. The public health nurses were helpful in initiating this project and bringing the profiles up to date.

Pine Ridge (James Tauer)

The fourth quarter turned out to be the busiest of the year; almost 19,000 prescriptions filled compared to our usual 14,000-15,000. All programs were maintained in operation, despite a workload that increased 13% over FY 1982. Prescription volume increased by another 10% over FY 1982, sterile preparations increased 50% over last year.

Rapid City (Douglas Kapaun)

During this past quarter, outpatient visits bobbed above the 10,000 mark. If that rate continues, and there is no reason to doubt it won't, we will have reached 40,000+ OP visits a year. Only two years ago we were approaching 30,000 visits.

We continue to maintain high pharmaceutical standards at this service unit. Pharmacy has protocols for treating illnesses of an acute nature. Prescriptions from outside sources are reviewed by the pharmacist and, as part of the patient's history, are included in his/her medical chart.

Private consultation between patient and pharmacist is provided as one of our services in our consultation room contiguous to the pharmacy. Most patients are more willing to be more open to the pharmacist during private consultation than you will sometimes find with the doctor.

The physicians, with the professional staff, make patient rounds every Monday morning. Pharmacy makes its own rounds reviewing patient's charts and orders, a daily habit.

Pharmacy has its own TB follow-up monitoring program. In conjunction with the Public Health Nurses, the Community Health Representative, and the Pennington County Health Department, tuberculosis treatment difficulties have been kept to a minimum.

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Winnebago (Mike Gecewich)

Workload statistics for the fourth quarter of FY 1983 are comparable to previous periods. However, the total annual workload has increased by about 4,500 prescription equivalents from FY 1982 to 1983. This is a percentage increase of approximately 10% over the past fiscal year.

We continue to supply a significant amount of "primary care" to outpatient clinics. One out of every 3 or 4 patients is serviced only by the pharmacist.

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Area Highlights

Anchorage (Roger Dinwiddie)

The workload increased 9.2 percent for FY 1983 (216,186) as compared to FY 1982 (197,939). The sharp increase in outpatient workload was due in part to the shifting of filling discharge prescriptions from the inpatient pharmacy to the outpatient pharmacy in January.

The following students worked in the pharmacy during the past six months as part of a clerkship/externship of their respective universities:

Barbara Nappier - St. Louis University
Kathryn Ketron - University of Tennessee
Anthony Retuccio - Ohio State University
Lisa Caswell - University of Rhode Island
Sandy Kline - University of Toledo

The pharmacy chose to implement the mobile decentralized pharmacist concept of unit dose distribution. This style of unit dose utilizes a pharmacist with a master medication cart (a pharmacy dispensing station on wheels) to dispense medications and handle clinical considerations at the nursing stations rather than within the pharmacy. As part of this concept we utilize the nursing medication kardex as the pharmacist's dispensing kardex and thus eliminate all the potential discrepancies that can develop when the pharmacy has its' own separate kardex in the pharmacy. In addition, it appears to be more efficient in terms of personnel than the other systems currently being used.

Bethel (Carroll Mortenson)

There has been quite a bit of confusion about who is going to do what as far as Hepatitis-B immunizations. We are monitoring and sending out medications (HBIG and Heptavax) to those children both to HBsAg positive mothers. We came up with a new card for recording the dose sent out and the days they are given. Also we made up a file for these cards so we could keep track of them better. This system has worked out pretty well. A problem with the system starts at this time of the year, with freezing conditions. The Heptavax is very cold sensitive, so we try to find someone going out to the village (PhN, MD, etc) to hand-carry doses.

The pharmacy has taken on the responsibility of explaining X-Ray preps to patients. Patients were not coming in prepped properly so pharmacy was asked to discuss the preps with the patients. The nursing staff in OPD was doing it prior to this time.

I made a presentation to our Native Health Board explaining the workings of our pharmacy here at Bethel. I went through everything from educational background to typing a label properly, to patient counselling, to who closes off the lights at night. The presentation seemed to be received quite well, no one threw rotten tomatoes. I feel it is good for each health board member to know what is going on in the hospital that their decisions effect. I was glad to have this opportunity.

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Fairbanks (Margaret Brophy)

On a field trip to Kaltag, Anna Madros took me to the homes of some of our elderly patients who participate in the auto refill program. I was delighted to have the opportunity to meet some of the people and finally associate a face with their auto refill forms. Anna pointed out that several patients have difficulty reading or seeing their prescription labels. With the next set of auto refills we will begin a pilot project of marking medications for these patients in some simple way (yet to be devised) that will make the directions more clear. If we have any success with this trial, we hope to offer it to patients with similar difficulties in other villages.

Ketchikan (Robert Adams)

We have again submitted our Hypertension and Family Planning Protocols to the Pharmacy and Therapeutics Committee. We hope to have them adopted at the next meeting. These will expand the role of the pharmacy in the management of these chronic conditions and allow the pharmacist to make medication change or order laboratory studies, based on his clinical judgment.

In September, we were surveyed by JCAH. The pharmacy was the only department that did not have any deficiencies. We were also complimented on the fine working relationship that we have with the Medical and Administrative staffs, and the support that we provided them. They were most impressed with the use of the HP 41 and the clinical support that we provide.

I attended the Annual Non-physician Primary Care Providers Course in September in Anchorage. It was nice seeing Gary Copeland again. The seminar was well done and the topics were timely.

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ALBUQUERQUE AREA

Area Highlights

Acoma-Canoncito-Laguna (Robert Waudby)

Our workload decreased slightly, as we would seasonally expect, but it was still higher than last year, both for the quarter, and for the whole year. The entire service unit workload increased by approximately 10% (inpatient admissions and outpatient visits) as compared to FY 82. Also, costs were higher, both for inpatient and outpatient areas. Part of the reason for this is we are providing a higher level of care on inpatients, such as the surgical patients from Cibola hospital. This has increased not only the number, but the type of admissions. Outpatient costs are higher, probably due to increased prescribing of drugs, and also the use of more expensive agents for these patients.

In March, we temporarily took responsibility for providing services to Laguna Rainbow Nursing Home (a private, tribal corporation that provides the nursing home for Laguna tribal members) when the existing pharmacy contract was ended. By August, we had become permanently in charge of the pharmacy services for the nursing home.

We experienced a much higher inpatient workload during the year, primarily due to the addition of surgical patients who are operated on at Cibola Hospital and then admitted to ACL. While the length of stay is generally shorter, the number of admissions, and the type of drugs used has changed dramatically since last year. Since this program only began in June, the yearly statistics do not fully reflect this.

Santa Fe (James Yatsco)

Mr. Yatsco participated in a year-end evaluation of the Africare project to improve the management and distribution of pharmaceuticals in The Gambia, West Africa, August 3-22, 1983.

Laura Carver and Terry Green presented a CED workshop on vitamin-mineral-food supplements at the College of Santa Fe, School of Nursing.

Pharmacy quality assurance activities included the following major activities: outpatient antibiotic utilization review, human bite antibiotic therapy, unit-dose drug distribution audit and IV admixture service audit.

Mr. Yatsco represented the Albuquerque Area at the Annual IHS Area Pharmacy Officers' Conference held in Rockville, Maryland, September 12-15, 1983.

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Mescalero (Gary Lawless)

Workload, in terms of pharmacy workload units, is up slightly from FY 82. Total outpatient department visits are down about 12% from last year, and hospital admissions up about 10%.

Dulce (Jon A. McArthur)

Special thanks to Mr. Clete Bonnett who made possible the transfer of a Drug-O-Matic pill counter to the Dulce Health Center Pharmacy. The counter is now in operation and is a tremendous aide in dispensing.

Zuni (Robbin Nighswander)

A different approach to Drug Utilization Review is being taken by the facility to prospectively monitor certain antibiotics. Mr. Clark has worked with the Medical Staff to develop criteria for Gentamicin, Clindamycin, Cefazolin, and Cefoxitin usage in the facility. Pharmacy will be applying and gathering data utilizing these criteria next quarter. Plans are to expand this monitoring to outpatient cephalexin usage as the criteria are developed.

Towaoc (Steven Bowman)

The National Arthritis Foundation sent a team here for one afternoon of presentations and grand rounds on several of our more severe rheumatoid arthritics. It is hoped that we can use their input to create a chronic care clinic for arthritics one morning each month.

A course was presented twice monthly for the quarter to diabetics on drug therapy for adult onset diabetes. The primary discussion was on insulin and proper methods of its' administration, but oral agents were also briefly discussed.

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BEMIDJI AREA

Area Highlights

Bemidji (Tim Svoboda)

The Area Branch Chief attended the annual Pharmacy Branch Chief's meeting in IHS Headquarters in mid-September. The meeting featured presentations by Dr. Todd, FDA and other personnel. All-in-all, it was an excellent agenda and meeting.

The Area Branch Chief fulfilled recruiting assignments at the University of Illinois (Chicago), Ferris State College and the University of Wisconsin (Madison).

The JCAH performed a review of the Cass Lake Hospital this quarter. Three year accreditation was received as a result of this review. Ground was broken for an addition to the hospital which will include a substantially improved pharmacy (although the space allocation will still be well below the standards).

ASG Richard Ashbaugh included the Bemidji Area in a recent trip. He was able to visit the Cass Lake, Red Lake and White Earth facilities and meet the personnel. His presence and observations were appreciated by all concerned.

The staff at the Stockbridge-Munsee Health Center are working on a major emphasis area in diabetes. The pharmacist is participating in this project. A bulletin board was put together by the pharmacy and displayed in the waiting room for two months. The board graphically explained each part of a prescription label and the importance of using accurate measuring devices for liquid medicines. The pharmacist began learning how to take blood pressures in order to facilitate blood pressure screening and rechecks.

Cass Lake (Paul Nelson)

We dispense OTC and some legend drug for the following medical conditions after screening the patients: acne, aching muscles, athletes foot, constipation, cough-cold-fever, diarrhea, dry skin, sunburn, indigestion-heart burn, lice, general pain, poison oak/poison ivy, small skin cuts, sore throats, vitamin deficiencies, minor eye problems, and hemorrhoids. This screening process is done about 250-300 times a quarter.

The chronic care protocols developed from the refill program study are being used in the following conditions: acne, contraception, diabetes mellitus, heart disease, (angina, congestive heart failure), hypertension (essential), seizure disorder, and tuberculosis and hypothyroidism.

Cass Lake Indian Hospital has been chosen as a site for the Rural Physician Associate Program out of the University of Minnesota. A family practice student will be assigned to Cass Lake for 9 months during which time he or she will be exposed to all areas of the hospital including pharmacy.

Pharmacy is now involved with the Community Injury Control Committee to the extent of reviewing the emergency room log each month and then reporting accidents and accident trends to the committee.

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Red Lake (Alan Jorgenson)

Pharmacy services to our 28 inpatient beds continued with our 24-hour IV admixture and unit dose drug distribution systems. As compared to FY 1982, these indicators of pharmacy inpatient service showed a 2% increase and a 13% decrease, respectively. Discharge prescriptions dispensed cannot be compared as tabulation of these figures began in midyear FY 1982. The pharmacist continues his involvement with inpatient services in the form of daily medical rounds with the physicians, and separate chart review/pharmacy rounds. Using total prescriptions dispensed as a guide to outpatient pharmacy activity, FY 1983 showed a 16% increase over FY 1982. We ended the year with 43,710 total prescriptions dispensed, as compared with 37,672 for FY 1982. We continue to provide individual private consultation to our patients as time and need permit. Once weekly field coverage to our satellite facility in Ponemah has remained, with a noticeable increase in issues of supplies.

Laura LaVoy presented a lecture on Food-Drug Interactions to a meeting of Aberdeen-Bemidji Area nutritionists.

FY 1983 showed a marked increase by pharmacy staff in community and in-house teaching. Educational instruction directed toward the community included, participation in two separate career days sponsored by the Red Lake High School and a hospital sponsored Health Fair. During the third week of March, Mike Clairmont spent considerable time and energy in the preparation of various presentations for National Poison Prevention Week. This included a poster contest and lectures on the dangers of poisons in the homes, for school age children; movies on poison proofing the household and a prescription bottle collection for the community at large; and special instructions to the HHA's on how they can identify possible dangerous situations in the homes. Lack of participation and enthusiasm by the community was most disappointing.

White Earth (Larry Pfeifer)

The White Earth Health Center is an independent Service Unit serving about 4,000 patients. In FY 1983, 24,308 patients were seen. A 7% increase over FY 1982. Pharmacy visits paralleled this increase in patient visits. Pharmacy prescriptions filled were up 8% from FY 1982.

The pharmacy continues to provide a high level of primary care. This past year pharmacy primary care visits and activities have become too burdensome and were severely limiting pharmacy time to carry on routine pharmacy tasks. As a result the following changes were made:

a) Enforced policy of nursing screening phone calls and patient requests to be seen.

b) Reduced by 50% the time available for pharmacist practitioner to see patients.

c) Instituted a physician initiated medication sheet and other timesaving forms to reduce transcribing and duplication.

d) Made efforts to obtain a staffing increase and/or an automated data processing system.

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The pharmacy developed standing orders to diagnose and treat conjunctivitis, a pamphlet on "Treatment of Fever" for patients, and a pediatric dosage schedule.

Keshena (Thomas Blumenberg)

Prescription volume has set record highs for this facility with an average of 135 prescriptions filled per day.

Pharmacists Blumenberg and Lewandowski are enrolled in a Wisconsin Educational Telephone Network (ETN) Program. The bi-weekly telelectures are covering a variety of new drug products.

A total of forty-four (44) home visits were conducted, eight (8) by Pharmacist Blumenberg and thirty-six (36) by Pharmacist Lewandowski.

Pharmacist Lewandowski attended the Computer in Hospital Pharmacy seminar on September 8, 1983. This seminar gave an overview of various computer systems available and was sponsored by the Wisconsin Society of Hospital Pharmacists.

Oneida (Ron Pytel)

Budgetary problems are a constant concern as we may find ourselves running out of funds for drug purchases. The presence of the permanent medical director will be a future factor in reducing prescription costs. In the past, physician turnover has affected the drug stock level. The pharmacists have been reducing expenditures by comparison shopping, utilizing the VA and governmental contracts, receiving drug samples from firm representatives and doctor's offices. Returning outdated drugs for credit is done also. The presence of those physicians and a physician assistant will cause an increase in pharmacy workload, drug inventory, drug purchasing and patient waiting time. There is also an increase in cost for outside physicians' prescriptions.

In August 1983, the pharmacists had dispensed 1,975 prescriptions with a daily average of 86. Last August, they dispensed 1,885 prescriptions with a daily average of 86. To date, the pharmacists have dispensed 85,522 prescriptions at a cost of $345,969.29.

Lac du Flambeau (Thomas Rotella)

There are many patients who only come to this clinic to get their prescriptions filled. This practice has created some concern with the medical staff, who feel that patients are not using the clinic as a total health care facility, but rather only as a pharmacy service. A new policy statement is being drafted and will be presented to the health board which will basically allow only patients who see a physician at our clinic to get their prescriptions filled here.

Mr. Rotella volunteered his time and expertise again this year to join the medical staff at the annual Mole Lake Bluegrass Festival. The festival was held from July 28 through July 31, 1983, on the Mole Lake Indian Reservation. Once again, as last year, the primary problem was alcohol abuse rather than abuse of other drug substances.

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BILLINGS AREA

Area Highlights

Browning (Everett Cox)

This has seemingly been a busy quarter for the pharmacy at Browning. Several areas impacting tremendously on pharmacy's workload both now and undoubtedly in the future are pharmacists' involvement in non-pharmacy service unit activities.

During the late fourth quarter, pharmacy ended use of the multivisit form to record med refills on all but nursing home patients. The reason this action was taken was that up to 10-20% or more pharmacy refills recorded on this form were not being copied by medical records, for submission to Billings, and incorporation in pharmacy/service unit workload. Also, given the problems inherent in our present triage system, and the fact that many "chronic" med patients are seen relatively less often than in the past, we felt it incumbent upon us to document our monitoring activities, something that the multivisit form failed to allow. In addition, there was a tendency for the multivisit form to clutter the chart, and cover such important things as health summaries and mass problem lists, when they were present.

As a result of favorable budget prospects for the new fiscal year, pharmacy plans to reintroduce some non-prescription cold meds that were previously deleted due to financial restraints. These meds, like pediatric and adult decongestants, etc., will tentatively be available only through patients being seen through clinic, and then only during pharmacy hours. Whether we again begin to offer these non-Rx meds over-the-counter as before remains to be decided, after consultation with the medical staff. Up to now, essentially the only OTC's given out by pharmacy are antacids and tylenol/ASA meds.

Tony Fisher continues to be involved in Service Unit housing. During the quarter he was also made one of the team building core leaders for the Service Unit. In addition he is also chairman of an ad hoc committee whose function is to advise the Clinical Director, SUD, and health board on possible ways to improve the outpatient clinic efficiency and operation.

Everett Cox remains very active in quality assurance programs at the hospital, and in the latter part of the quarter, was made JCAH Coordinator for the Service Unit. Everett continues to function as a pharmacist practitioner and coordinate/perform Holter monitoring at the Service Unit.

Pharmacy continues to keep profiles on patients receiving TB meds for active disease, and to initiate follow-up periodically in cases of suboptimal compliance. We have ceased however performing the same activity on patients receiving INH prophylaxis, because essentially nothing was being done with the information gathered. If it can be demonstrated that this information will be utilized, we will reconsider the change.

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Lame Deer (George Carpenter)

Our workload for FY 1983 showed a modest increase. Our overall workload is up 19.4%, some of which is the result of improved reporting and some is due to the 16.3% increase in the number of prescriptions filled. In this last quarter we had an increase in the number of prescriptions filled of 49.7%. The increase can be attributed to: (1) the return of the OTC drug and (2) to having a fall that started off like it did several years ago with lots of colds and flu.

Now that our interregnum is over, some things have improved. Our SUD came up with an extra $10 million for OTC drugs. At this writing, we have ordered more OTC's and most have arrived. We were very choosey about which OTC's we ordered and established an eclectic OTC policy.

Fort Washakie (James McKnight)

Workload statistics showed a moderate increase this quarter when compared to 4th quarter, FY 1982. Prescriptions were up approximately 9% for the Service Unit, probably due to the new physician staff. The number of prescriptions for the whole year however was exactly the same as for last year. We would probably have had a sizable increase in prescriptions had it not been for the cutback in the over-the-counter drug program and the ineligibility of non-Indian spouses.

Inventories of drug supplies are now at good levels once again. Extra money was given to the pharmacy near the end of the fiscal year and the storeroom was replenished. We have recently turned in our request for next year's drug budget. It would be nice if an appropriate amount of funds were budgeted to us early in the year negating the need for supplemental funds at year-end. It would certainly be easier to control our budget if we got a reasonable budget early in the year and did not experience "feast to famine" times from one month to the next. We were however very glad to get the year-end money to build our supplies back up.

Fort Belknap (Gary Buehler)

Workload fell this quarter from a daily prescription average of 92 last quarter to 84. Again, I attribute this decrease to staff turnover and the slower summer season. Patients really have to be ill to brave the Ft. Belknap mosquitoes of the summer.

In the next quarter I would like to initiate some ongoing DUR's on the success of two recently introduced treatment regimens. One is the single dose therapy for UTI's and the other is the switching of many of our adult onset diabetics who are presently on insulin to oral anti-diabetic therapy. I hope to present this proposal at our next P and T committee meeting.

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Thanks to Mr. Ashmore, the department received three new references this past quarter. We now have available the new edition of "Handbook of Clinical Drug Data," "Drug Interaction Facts" and "Emergency Drug Reference." I have also ordered and received "Guidelines for the Administration of Intravenous Medications to Pediatric Patients" and am awaiting our new editions of the ASHP Formulaties.

I have tried to keep an accurate account of all drug information requests. It seems that the pharmacy is receiving more requests than I had realized for drug information from the nurses and physicians. I, of course, welcome these requests and hope they continue.

Lodge Grass (Robert Tonelli)

The Lodge Grass Clinic has set up a code team with the Pharmacist as a member. The Pharmacist is also a member of the Quality Assurance Committee for Crow Hospital. This committee is beginning regular meetings and has recently passed a Quality Assurance Plan for use in the hospital.

I was a participant in continuing education at the University of Montana. The course on antibiotic therapy was a one week session. It was well presented and well worthwhile for any possible participants in future years.

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NAVAJO AREA

Area Highlights

Window Rock (Gene Smith)

The Chief Pharmacist attended the IHS Area Branch Chief's meeting in Rockville, September 11-16, 1983. He subsequently was assigned to an AD-HOC committee for a headquarters report on pharmacy staffing and attended a committee meeting September 28-30, 1983, at Santa Fe IHS Hospital.

The outpatient workload is consistent with past 4th quarter reports in terms of total number of prescriptions dispensed and the numbers of stock containers issued to ambulatory units.

The inpatient workload continues to show growth (14%) in unit doses dispensed to the unit dose floors. IV admixtures increased some but not higher than last quarter, and we realize that July was the only month in this quarter that we prepared any hyperalimentation solutions. Previous quarters had shown a decline in inpatient stock containers issued but this quarter showed a reversal of this trend for reasons yet unknown.

Non-demand workload remained at consistent levels with last reports as pharmacy was able to maintain medical rounds, inservice training, ward inspections, drug information and a few committee meetings despite some shortages due to summer annual leave and meetings in IHS.

The new pharmacy residents, June Humphrey and Cathy Pierce, began their two month orientation in July.

Chinle (Richard Draper)

Inpatient Activities: There were 3,404 unit dose prescriptions dispensed to the 41 students at the Chinle Valley School. At the Chinle Nursing Home, there were 27,048 unit dose prescriptions dispensed to the 60 to 80 patients. On August 1, 1983, ten patients were admitted to the Chinle Comprehensive Health Care Facility. There were 103 admissions during August and September. During this period, 1,044 unit dose prescriptions were distributed, 1,878 stock containers issued, and 576 intravenous additive preparations distributed to inpatient services.

Outpatient Activities: There were 12,806 outpatient prescriptions dispensed from the Chinle Comprehensive Health Care Facility, 96 prescriptions from the Rockpoint Clinic and 628 prescriptions from the Pinon Clinic.

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Crownpoint (Robert Staley)

Emphasis this quarter continued on management functions with an increased stress on Quality Assurance activities. The updated Pharmacy Policy and Procedure Manual was completed, approved, and distributed during July. A current approved formulary list of medications was distributed to the practitioners on September 28th.

A follow-up audit on prescription writing standards was completed during this quarter and presented to the P & T Committee and to the Quality Assurance Committee.

An improved procedure for reporting Adverse Drug Reactions (ADR's) to the pharmacy with a follow-up report to the involved practitioner(s) was initiated.

Ft. Defiance (Ben Fox)

The workload for this fourth quarter of fiscal year 1983 showed a slight increase over the third quarter's statistics and a comparable figure to last year's fourth quarter. There were some notable changes between the third and fourth quarters. Rounds with physicians dropped drastically with the new medical coverage for inpatients, which prevents major involvement by the pharmacy staff. Acute diseases also dropped as expected with the curtailment of pharmacy service in this area, in conjunction with the medical staff. The pharmacy department provided a four (4) lecture series on pharmacology to the nursing staff during the months of August and September. The response to these lectures was very favorable and requests for more presentations in the near future have already been proposed.

The ratio of workload units between outpatient and inpatient was the basis for cost division between those two areas. The results showed the average inpatient received $34.95 worth of medications while the average outpatient prescription cost $2.72 per item. The cost would be lower if the number of outpatient visits were used instead of prescriptions.

During the quarter the medication order and inventory forms were revised on several of the nursing units to reflect current usage and reduce overstock of medications. In conjunction with this the pharmacy is developing guidelines for the direct IV administration of medications by nursing personnel. Nursing administration had procrastinated on this issue and a final report is expected soon.

Shiprock (Donald Thelen)

This past quarter workload was up slightly. The largest increase in workload seems to be in the inpatient area. This is probably due to a full staffing in our Surgery and Intensive Care Unit. Our inpatient census has not increased significantly, however, critically ill patients are now being treated at Shiprock rather than being transferred to another facility. Our goals for the coming year will be to streamline our clinical program and spend more time on patient rounds and thereby provide more input in patient drug therapy. Much of our time now is spent on the technical aspect of preparing IV drug therapy and unit dose medications. With the help of another technician our input in monitering drug therapy could be greatly improved.

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Tuba City (Vi Dwight)

This year has been one of the worst in regard to staffing. The administration at our facility froze a pharmacist position, so we operated during the entire year one pharmacist short. Comparing staffing patterns of the IHS facilities per OPV we should have eleven pharmacists but we have only five pharmacists. It is a credit to the pharmacy staff that we are able to manage so well under these trying conditions and I would like to extend my sincere appreciation to the pharmacy staff for their super efforts.

Some of the pharmacy department's objectives for the coming year are:

1. To make every effort to regain normal staffing for the pharmacy department so as to assure that full pharmacy services can be maintained.

2. To begin planning for eventual computerization of pharmacy services.

3. To improve the methodology of prescriber writing of outpatient medications so that there is no duplication of effort.

4. To provide a means by which the patient's first contact in the outpatient department will include questions regarding the patient's allergies.

5. To make every effort to obtain a good drug information retrieval system such as the Iowa Drug Information System.

6. To obtain or develop access to some methodology whereby the yearly updating of the formulary is made easier.

7. To continually improve and upgrade our Quality Assurance Program.

All pharmacists were able to attend the Tri-Area Pharmacy Continuing Education conference at their own expense in Flagstaff, April 29 - May 1, 1983. Additionally, Tim Ames and Vi Dwight attended the ASHP Mid-Year Clinical Meeting in Los Angeles, California. Barbara Sorrell and Vi Dwight attended an Infectious Disease Seminar presented by the University of Arizona in Tucson. Barbara also attended a Quality Assurance Seminar in Phoenix, Arizona. Tim Ames attended two seminars, one on Nutritional Therapy and one on Intravenous Therapy which was presented by the Travenol Labs in California.

We prepared an information sheet on the Tuba City pharmacy department and sent a copy to all the schools of pharmacy in the U. S. in an effort to obtain more than one pharmacy extern. As a result, this summer we had three pharmacy externs and one etho pharmacognosy student. Two were from Ohio State, one from the University of Missouri at Kansas City, and one from the University of Washington.

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OKLAHOMA AREA

Area Highlights

Oklahoma City (Richard Church)

The total workload for the Oklahoma City Area for FY 1983 was 1,307,480. This represents a decrease of 4.8% when compared to FY 1982. This parallels area wide decreases of 3.6% in outpatient visits and 4.8% in adult and pediatric admissions. These decreases were largely due to changes in eligibility and dispensing policies which took place at the beginning of the second quarter.

Inpatient workload increased by 1% overall. While the number of inpatient prescriptions and unit doses dispensed decreased, the IV admixture services, clinical counseling, rounds with physicians and patient monitoring activities all showed increases.

With a decrease in the total number of outpatient visits, the number of prescriptions dispensed and the number of pharmacy primary care visits also decreased. These decreases were partially offset by increases in patient education and quality assurance activities.

We continued to have students from SWOSU School of Pharmacy in our facilities as part of their Professional Practice (Clinical) sequence. All Indian Health Service attended a faculty preceptor's meeting. In attendance were all the community and hospital preceptors for the Southwestern Oklahoma State University School of Pharmacy. The meeting dealt with the teaching program for pharmacy students and their externship experiences in community and hospital pharmacies. We have had a very successful relationship with SWOSU for a number of years. That relationship has proved to be one of the most successful recruiting tools for the Indian Health Service pharmacy program.

The Oklahoma City Area Pharmacy Officer's Conference was held in Oklahoma City on May 13 and 14, 1983. The program was attended by a total of 54 pharmacists representing all service units in this area and five pharmacists from other areas. All pharmacists from this area attended the meeting at their own expense. The meeting was very well received and attended.

Richard Church, Chief, Area Pharmacy Branch and Tom Ambrose, IHS Clinical Support Center Center were detailed to Africare as technical consultants in January 1983 to go to The Gambia in West Africa to evaluate progress in the project. The project began during the previous year by Africare using the skills and talents of three IHS pharmacists, Mike Hope, Oklahoma City Area; Jim Yatsco, Albuquerque; and Tom Ambrose, Clinical Support Center.

An article was published in a special edition of U.S. Medicine on training activities in Federal services. The only article included on pharmacy services featured the IHS Clinical Pharmacy Project. The Chief, Area Pharmacy Branch from the Oklahoma City Area was involved in the development and planning of the project. The article was based on the first area seminar which was held in the Oklahoma City Area at the Carl Albert Indian Hospital in March of 1982.

The IHS Physician Extender meeting was held on May 11-13, 1983, at Pebbletree Inn immediately preceding the Area Pharmacy meeting. All pharmacist practitioners attended the meeting as well. The program was very good. Mr. Tom Ambrose of the CCEC is to be commended for a fine job of coordinating the meeting.

Nan Locklear, pharmacy student at the University of North Carolina, served as a COSTEP at the Talihina Indian Hospital. She spent most of her time at the hospital but was exposed to the other health centers of the service unit as well. She also did an additional rotation at the Carl Albert Indian Hospital.

Ada (Chris Konrad)

Workload continues to steadily increase, with 150,000 workload units for FY 1983, even though drastic program cuts were made in FY 1983 due to budgetary constraints. The following actions were taken in March 1983 to decrease drug expenditures:

a) Discontinued filling prescriptions written by non-consultant private practitioners.

b) Cancelled contract with local pharmacy to provide contract pharmacy services.

c) Discontinued outpatient dispensing of selected OTC drugs.

d) Discontinued outpatient dispensing of non-steroidal anti-inflammatory drugs.

e) Discontinued dispensing disposable insulin syringes/needles to outpatients.

Traditional IHS pharmacy services are provided to outpatients utilizing four private patient consultation rooms. Direct patient care services are provided by pharmacists under the Acute and Chronic Care Pharmacy Protocols. The number of patients currently assigned to each Pharmacy Chronic Care Protocol is as follows: Oral Contraceptive - 178; Hypertension - 90 and INH - 6. The outpatient pharmacy is also actively involved in diabetic and prenatal patient education classes.

The pharmacy is actively involved in performing on-going quality assurance activities for both the inpatient and outpatient services provided. Monthly written quality assurance reports identifying the quality assurance activities performed during the month and also identifying problems that need solutions is submitted to the hospital quality assurance coordinator. Through the service unit P & T Committee, the pharmacy is also actively involved in drug utilization review and drug audits.

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Wewoka (Ed Jeter)

The Wewoka Indian Health Center is a relatively new facility; patient services were begun here in March 1978. The center employs 43 full-time staff including two physicians, three dentists, one physician assistant, and two pharmacists.

Outpatient visits went down this fiscal year to a total of 25,724, a 9.7% decrease compared to last fiscal year. This decrease was probably due to a combination of factors, with the main cause being changes in patient eligibility policies in January resulting in loss of eligibility of non-Indian spouses for services at our facility. Pharmacy workload units totaled 46,162 and this also represented a substantial decrease of 18.2% from last year.

The significant workload decrease in the last two quarters was primarily due to major changes in our drug dispensing policies which took place in early March. Our average number of prescriptions dispensed per workday dropped from 170 for the first two quarters to 105 for the last two quarters - a 38% reduction. Patient visits to the pharmacy fell to about 24% of total clinic visits, down from a high of 30.3% last fiscal year.

Visits directly to the pharmacy are apportioned on the average about 40% for acute and 60% for chronic care. The chronic care visits are primarily for prescription refills on medications for patients who have missed appointments, lost their medications, etc. Also included are a large number of patients refilling oral contraceptives and we do a comprehensive review on these patients. The majority of patients for acute care have problems such as URI's; eye, ear and throat infections; head lice; or various skin problems.

Patients are educated about medications through various means, including prenatal class lectures, diabetic class lectures, bulletin board displays, and drug information handouts. Susan Carl, Deputy Chief Pharmacist, did an excellent job of preparing a diabetic lecture covering these topics: "Why Water is Important to Your Health," "How Your Kidneys Work" and "Bladder or Kidney Infection." Large multicolored posters, a lab urine culture plate, and tubes of blood cells, plasma and urine from the lab, were used to illustrate the important points. Patient response and interest was very good, with more than the usual amount of questions and discussion.

Ed Jeter, Chief Pharmacist, attended the Senior Citizens luncheon at Calvin, Oklahoma to moderate a discussion of the film, "Wise Use of Medications" shown by their nutriutionist, and to answer questions about medications from the group.

We have tried to do a more thorough job of patient medication counseling over the past six months since we have fewer prescriptions to dispense and more available time. We have made a special effort to tell all our patients on oral contraceptives about the risks of smoking. Also, we've redoubled our efforts to interview patients about possible drug sensitivities, and to see that this information is recorded accurately on the problem sheets and sensitivity labels.

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Susan Carl has been a very active member of the Quality Assurance Committee this year. She worked on a project designed to improve entries in patient's charts and especially in recording on the Problem List sheets in the front of the chart. She did an initial survey of about 100 charts, then coordinated a Problem-Oriented Medical Records workshop for the clinic staff last fall. The workshop included an instructional videotape with practice cases and a study guide manual (materials were obtained from CCEC). She completed a follow-up audit of 100 charts this summer to evaluate the project. The audit shows a significant improvement in problem list recording. Another audit will be done in six months to see if this is a continued trend.

Completion of the Pharmacy Practitioner Training Program in March 1982 has allowed Ed Jeter to more confidently and appropriately manage a greater variety of acute care patient problems in the pharmacy. Also to do some scheduled physical exams on Thursdays, primarily school sports physicals.

Claremore (Linton Angle)

The Claremore Comprehensive Indian Health Facility is a six year old general, medical and surgical hospital serving the people in a ten county area of northeastern Oklahoma. Outpatient visits and inpatient days have decreased approximately 10% from 1982 thru 1983, due to the discontinuance of services to non-Indian people. An average of 400 new charts are made each month.

The following are a few of the services and procedures which have been in effect for several years: Consultation of patients; OTC dispensing; chronic and acute protocols for primary care; inpatient clinical pharmacy services, including monitoring of dosage regimens, physician rounds, chart reviews and antibiotic surveys; unit dose system; IV admixture service; prescription refills; student affiliation program with SWOSU; inpatient discharge consultation; drug information; and poison control.

Antibiotic usage assessments are being conducted monthly according to established criteria. The same criteria are being used for both the inpatient and outpatient areas and the results are reported quarterly to the pharmacy and therapeutics committee and the quality assurance committee.

Jay (Ron Cleveland)

The total workload units for FY 1983 was 18,149. Of this, 14,010 were prescriptions dispensed and there were a total of 3,425 patients for primary care. Of the 16,001 total outpatient visits for the year, 21.4% were provided by the pharmacy. At this facility the pharmacist is also responsible for the X-ray Department. During 1983, 234 hours were spent in X-ray.

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Miami (Ted Bearden)

The pharmacy workload this month has averaged 134 prescriptions, 12 X-rays, and 35 patients per day. Our changeover to the Ada supply system has gone smoothly. Although we have been backordered on several items, these have been filled promptly.

Glen Prewett attended a 2-day contining education seminar in Tulsa presented by SWOSU School of Pharmacy covering new drug therapy and coronary artery disease.

Pat Cox attended a continuing education seminar in Stillwater on pharmacy law.

Clinton (Ralph Causey)

The workload for the hospital pharmacy in fiscal year 1983 was 65,049 workload units. This is a decrease in workload of 12.8% from last year's workload of 74,580. This is not nearly as bad as it sounds as there was also a decrease in pharmacists at the hospital from three to two (a 33% decrease) and no more field visits to Concho except for leave coverage. Other sources of decrease in workload were the decrease in inpatient work, complete physician turnover, and butget cutbacks in some OTC and prescription items.

Inpatient prescriptions are filled directly from inpatient charts and placed into the individual patient drawers in the nursing medicine cart. The amount dispensed depends on the automatic stop orders and physician orders. The exception to this is controlled drugs which are on perpetual inventory. The IV additives (mostly antibiotics) are mixed by the pharmacy and if stable the admixtures are made up to last through the weekend. All drug areas, including emergency room cart, are routinely checked by the pharmacy. A pharmacist and pharmacy student, when assigned, make rounds with the physicians daily. Discharge counseling is done either at bedside or in the pharmacy.

Outpatient prescriptions are filled from the patients chart after a review of clinical data and plans. Patient counseling is provided on most every outpatient visit, with discharge meds, over the telephone, and just about anywhere the pharmacist happens to be.

The Pharmacy Practicum, or student affiliation program, of which the pharmacists are off campus instructors and preceptors for four or five pharmacy students each year, is an eight week course affiliated with the Pharmacy School at Southwestern Oklahoma State University at Weatherford, OK. The students in this program are in their last semester of pharmacy school. The students experience every phase of operation at the hospital and some students make field visits at our satellite clinics. They also benefit the hospital in that they are an extra staff member at times and they stimulate the pharmacy staff to keep up with the developments in the field of pharmacy as well as the latest drug information.

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Holton (Patrick Halton)

The prescription count has held relatively steady at about 2,400 per quarter. This is reflected in a quarterly workload unit count of about 3,400 which has also been relatively constant. The last quarter showed a small decrease due to a change in pharmacists during that time and the resulting time lost during transition. The workload shows a significant decrease from that shown in FY 1982 (FY-1982 - 20,426 WLU and FY-1983 - 14,586 WLU). This is due in part to a significant decrease in non-prescription drug dispensing and a more conservative approach to unit counting. The X-ray department continues to be a large part of the pharmacist's workload.

On-Going Activities: Any actions taken by the pharmacist that relate to patient care, are noted in the medical record. Prescriptions are written in the medical record by the clinic physician; the quantities and other pertinent data is entered by the pharmacist. Prescriptions written or called-in by outside physicians are also noted in the medical record by the pharmacist. A limited acute care program is provided by the pharmacist and clinic nurse, in the absence of the physician. This care is governed by a set of standing orders and problems not covered by these orders are referred to other medical facilities on a contract basis. A small satellite clinic is maintained at White Cloud, Kansas. The medical staff from Holton, drives to White Cloud twice each month to hold routine medical clinics.

After reporting to the Holton Clinic in August of this year, I was able to attend several training sessions at the Topeka Radiology clinic to acquaint myself with X-ray techniques and safety procedures. This was a very helpful activity and allowed me to carry on the additional duties of X-ray with a minimum of problems.

Anadarko (Gordon Johnston)

The total workload for Anadarko for FY 1983 was 31,708. This is down from last year's total of 38,345. The decrease was due to changes in eligibility requirements for service, not filling prescriptions from non-IHS physicians, drastic cuts in non-prescription drugs, limiting supplies of certain prescription drugs and limiting contract prescriptions. All these were implemented due to severe budget problems experienced during the year.

The major emphasis for the remainder of FY 1983 and on into the next fiscal year will be to work on the planning and determination of requirements for the new clinic which is scheduled to be open by the winter of 1984. The new facility will have a staff of three pharmacists. The pharmacy will have individual consultation rooms and be computerized. A great deal of time will be required to update manuals, update primary care protocols, revise existing programs and provide assistance wherever needed in making the move into the new facility.

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Carnegie (Gary Blair)

The fourth quarter workload showed a small increase over the past quarter. The number of prescriptions continues to increase somewhat, even though the antiarthritics and OTC's were deleted. Most of those affected have been understanding, but it is unfortunate that the elderly on arthritis medications seem to get the worst of the cutbacks. Very few of the elderly in this immediate area have the means to purchase their own medications. As we have exhausted our supply only recently, we are just now beginning to see these people back. I have wondered if the tribes would be willing to pay for these medications from private pharmacies, provided they had the funds available.

Lawton (Dan Hausman)

This fiscal year the pharmacy workload was approximately 144,500, a slight decrease over that of fiscal year 1982. The workload sighted here does not include the workload units generated at the Anadarko Health Center or Carnegie Clinic. The slight decline in workload noted can be attributed to the following budgetary constrictive reasons:

1) Not filling two staff pharmacy officer positions (vacated 3/31/83 through 10/10/83 when one position was filled). These positions represented a loss of some 29% of our pharmacy staff, and had not been filled because of an anticipated budgetary deficit in the hospital 01 accounts.

2) Decline in the outpatient clinic load (limitations of appointments and not seeing non-Indian spouses).

3) Cuts in the OTC pharmacy program.

4) Not filling of non-IHS physician prescriptions and prescriptions for certain items e.g. NSAI, etc.

The Lawton Indian Health Pharmacy Total Parenteral Nutritional (Hyperalimentation) services were first implemented in FY 1980. Procedural guidelines along with the necessary flow sheets for the TPN program were prepared by the pharmacy staff with input from the medical staff, nursing department and the dietition.

This past year has indeed been very fruitful, despite the severe budgetary problems. We have seen many positive changes in the pharmacy program, and continue to provide the highest level of pharmacy services within our resources (staff, budget, & physical plant). As pharmacy continues to become more actively involved in direct patient care activities, one's staff must be increased accordingly. Expansion of the pharmacy outpatient monitoring activities can't be accomplished without the addition of qualified personnel. Expansion of the unit dose program and other related inpatient clinical services necessitates additional staff.

All health professionals are constantly undergoing self-examination & re-evaluation of the role they play on the health care team. As their role changes, various staffing adjustments must be made to accommodate these new functions. Pharmacy is such a profession continually striving to raise patient care levels through assuring the safe and rational use of medications within and outside the hospital.

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Sapulpa (Cheri Levy)

The following figures indicate the activities in Fiscal Year 1982 as compared with Fiscal Year 1983.

	1982	1983
Total Clinic Visits (APC)	13,942	13,069
Pharmacy Visits - Primary Provider	3,466	1,963
% of Total Visits	24.8%	15.0%
Workload Units	23,291	15,749

This fiscal year there was a decrease in total outpatient visits and pharmacy visits. This decrease may be due to the following: 1) The ineligibility of non-Indian spouses; 2) No longer filling outside prescriptions; and 3) The discontinuance of non-prescription medication.

Cheri Levy attended the Second Annual Diabetes Symposium at Rogers State College in Claremore, Ok in September 1983 and the Oklahoma City Area Pharmacy Officers Conference in Oklahoma City in May 1983.

Pawnee (Michael Brown)

The Student Affiliation Program with Southwestern Oklahoma State University enables junior or senior students at the School of Pharmacy to spend eight weeks (as part of their curriculum) at our pharmacy working as a Pharmacist Extern. The program enables these pharmacy students to apply the knowledge they have acquired over the past four or five years in an academic setting to actual clinical problems that they encounter with patients, paramedical personnel, and physicians.

A medication history is compiled on every outpatient that comes to the pharmacy. The medication history is recorded on a Medication Profile form developed by the pharmacy staff. After a medication history is taken, the Medication Profile is inserted into the patient's chart behind the problem list. The Medication Profile Form is divided into two sections, the lower portion of the form is used to list all medication that the patient takes for chronic diseases. The upper portion of the form is used to list other medications that the patient is taking. We also list all medications that a patient is buying at a drug store. All medications a patient takes both prescription and over-the-counter are listed on the Patient Profile Form.

Since we have expanded the traditional role of the dispensing pharmacist to include primary care, we have found it necessary to have all patients requesting a pharmacy visit to have preliminary screening by the clinic nurse. This relieves the pharmacist from taking blood pressures, weights, temperature, etc., that are now required on most of the patients requesting a pharmacy visit. It is now standard procedure for the screening nurse to have these base line patient evaluation screening procedures done before the patient presents himself to the pharmacist.

The pharmacy staff has developed 135 Patient Medication Instruction Sheets. These Patient Medication Instruction Sheets are used as a guide by the pharmacist when instructing patients about their medication. After pharmacy consultation has been completed the Patient Medication Instruction Sheets are given to each patient for reference after they leave the pharmacy.

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White Eagle (William Welch)

Workload statistics from the most recent quarter indicate a four percent decrease when compared with the same period in 1982. Policy changes affecting traditional pharmacy activities have had the most impact on this reduction. There have been marked increases in non-pharmacy workload, primarily due to accepting more responsibility in areas of Administration, Supply Management, and Quality Assurance. A measurable workload decline was also noted following the January 10, 1983, memo from Area Office changing eligibility of non-Indian spouses.

In cooperation with the Tuberculosis Division of the Oklahoma State Department of Health, the pharmacists maintain drug receipt records on forms the State provides. A copy of this record is provided to the Community Health Nurse at the clinic to assist in assuring patients are complying with recommended therapy.

In the interest of reducing patient waiting time, the pharmacists assist the laboratory technician one to two mornings per week during diabetic clinic. In performing serum glucose and test strip urinalysis determinations, they allow the laboratory tech to proceed with microscopic UA's and other more extensive tests. This provides lab results in a quicker fashion, the physicians can interpret the results and begin seeing patients earlier, thus reducing the amount of time the patient must wait.

In June, 1983, both William Welch and Gale Goeden were awarded the Hazardous Duty Award Certificate and Ribbon. Service Unit Director A. N. James presented the awards for service performed while in the BMS -- Mr. Welch while in Seattle and Mr. Goeden while in New Orleans.

Shawnee (Dennis Gillham)

During this last quarter we have averaged 130 prescriptions per day. This is somewhat misleading because things have picked up considerably during the last month. We have been able to restock our drug supply to a level comparable to this time last year, and have averaged over 200 prescriptions for the last several days. We do not have all of the OTC drugs that we use to carry, but we are pretty close to having all of our former prescription items. We were able to do this as a result of the year end money and also about $7,000 in equity program money. Now that we have the drugs to dispense, there are a number of people signing up for the pharmacy primary program for treatment of cold symptoms and other minor ailments.

We have the potential for developing a good pharmacy primary care program now that we have three pharmacists on our staff. I would like to see each of the pharmacy staff receive some training in primary patient care, mainly physical assessment. We are currently operating a primary care program within established guidelines, but none of the pharmacy staff including myself has ever received any formal training in primary care. During the upcoming year if funds are available, I hope that we will be able to receive some training in the form of seminars, video tapes, or even possibly pharmacy practitioner training. We have the guidelines for a good primary program in our policy and procedure manual. All that is lacking is some form of supplemental training to make good use of the existing guidelines.

Broken Bow (Richard Burton)

The fourth quarter workload for pharmacy was about the same as the third quarter, 3,178 prescriptions compared to 3,219 respectively. Total prescriptions for FY-1983 was 14,197 compared to 21,113 for FY-1982. The 33% drop in prescriptions parallels the 30% decrease in number of patients seen at the clinic from November 1982 thru May 1983. This was the period just after the fire and until we moved back into the refurbished building. During this time period we were housed in a building one third the size of our clinic and were physically unable to see the same number of patients. In addition to the decreased patient load, during the second quarter, most OTC drugs were deleted from stock to cut back on expenses within the Service Unit. Instead of getting two to four prescriptions per patient, only one to two prescriptions were being written for acute complaints. This in effect reduced my total number of prescriptions by about 20%.

Hugo (Michael Mericle)

Workload units for the period beginning October 1, 1982 through September 30, 1983 totaled 30,091, which represents a 9% increase over FY 1982. Workload decreased significantly during the last two quarters as a result of not treating non-Indian spouses and the curtailment of non-prescription medications. The pharmacists provided primary care to 28% of the patients. The Facility Director's position requires up to 25% of available time, however, patient care takes precedence over administrative duties.

The workload units for FY-1983 do not provide an accurate representation of time and effort expended because:

1) The Pharmacy Quarterly and Cumulative Workload Report inequitably assigns the same workload conversion factor to pharmacy visits for acute diseases and chronic diseases, i.e., a URI in a eight year old takes considerably more time than a refill for respiratory allergies in a 25 year old.

2) The type of primary care for acute diseases delivered by some pharmacists will differ in depth and complexity from others, therefore the amount of time expended will also differ, i.e., primary care for acute diseases such as uncomplicated poison ivy will take less time than a headache.

3) There is no workload credit given to other non-pharmacy clinical activities performed such as lab and X-ray, nursing duties, etc.

4) No workload credit is given for duties of clinic administration.

The pharmacy takes part in a multi-disciplinary Diabetic Education Program for our clinic patients. The pharmacy provides a one month rotation in the teaching program covering all aspects of medication use and general concepts in the disease state.

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McAlester (Mark Horn)

This past year the pharmacists were the primary provider for 25.2% (3,000 patients through the 3rd quarter) patients while the physician was the primary provider for 29.5% (3,517 patients through the 3rd quarter) patients at this clinic. Medical Records Department reports that this Center now has 8,846 charts, an increase of 538 charts this year.

The Pharmacist Practitioner and the CHN have started a new program at Jones Academy, a boarding school for Indian children. Under the new program the pharmacist and nurse go out to the school twice weekly and provide primary care. This new program has two purposes: 1) to attempt to decrease the amount of school time lost; and 2) increase availability of medical coverage to the school.

This year the pharmacists at this facility have obtained the following training:

1) Pharmacist Practitioner Training consisting of three days of lecture presented by CCEC.

2) Pharmacy Training presented at the annual pharmacy meeting.

3) The "IHS Clinical Pharmacy Newsletter."

Tahihina (John Ware)

Workload during FY 1983 decreased by 19% when compared to the previous fiscal year. This is in part due to a decrease in patient load resulting from PL 97-394, and elimination of the majority of available OTC products due to budgetary constraints. Total workload units for FY 1983 were 95,817, as compared to 118,128 in FY 1982.

The pharmacy provides medicinal supplies for eligible patients at the local nursing homes as prescribed by a physician.

The pharmacy participates in Diabetic Teaching Classes and has been responsible for presenting classes weekly for four months of calendar year 1983.

Pharmacist Robert McGough received the Isolated-Hardship Service Ribbon. Pharmacists McGough, Ware and Wickizer each received the Hazardous Duty Ribbon for services performed while on duty at the Talihina Indian Hospital.

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Pawhuska (Cathy Foreman)

Due to budget shortages, filling of prescriptions from non-Indian health physicians was discontinued as was stocking of most over-the-counter medication. The clinic also discontinued the purchase of non-steriodal, anti-inflammatory medication due to lack of funds.

With the aid of Social Services, we established charts for patients in another local nursing home. We established policies for prescriptions, refills and delivery of medications. This will help serve more of our Indian population.

Shirley Juan aided Dr. Chesbro in setting up regular staff inservice meetings. Approximately fifty letters were sent to drug companies, state agencies and various organizations asking for information on films and/or speakers. They arranged twice monthly inservice for about three months, and then a schedule was prepared and distributed for each department to have specific dates to provide inservice.

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PHOENIX AREA

Area Highlights

Phoenix (Richard Herrier)

All the pharmacists at Whiteriver have attended the Advanced Cardiac Life Support (A.C.L.S.) course. Stephen Foster, Pharm.D., was certified as an A.C.L.S. instructor.

Two students from the University of Arizona College of Pharmacy began their clerkship/externship rotations in January, one at PIMC and one at Whiteriver.

The Service Unit requirements for Hepatitis B vaccine were surveyed and an appropriate amount requested from the Gallup Warehouse. I have served as coordinator for this process in the Phoenix Area.

Owyhee (Jim Mitchell)

The major accomplishment of this quarter was a visit by a clinic team to the outlying areas of the Service Unit. This team consisted of Steve Krotzer, M.D.; Terry Duke, RN-CHN; and myself. In 4-1/2 days, 98 patients visited the clinics held in Battle Mountain, Ely and Goshute; and about 20 patients were seen at the regular field clinic in Elko. In addition about 1,100 miles were driven to each of these sites. As a result of these visits the number of prescriptions mailed out from Owyhee has been reduced about 80%. This Service Unit has a vast, sparsely populated area to serve. I would recommend that the pharmacist be part of a similar team on a quarterly basis. The weekly field clinics at Elko are well attended. One of the vacant office's is used for the pharmacy. This allows some privacy for dispensing, counseling and discussions with the patients and physicians.

Parker (Mark Anderson)

Spent a considerable amount of time revising the pharmacy policy and procedure manual as part of preparation for upcoming JCAH review.

Spent parts of three days with Rick Herrier going over assorted problems in the pharmacy such as diabetic clinic, walk-ins, nurse screening, etc. Also reviewed policy and procedure manual for suggestions for improvement. Plan to develop protocols for pharmacy refills and walk-ins.

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Keams Canyon (James Neighbors)

Automated prescription services has exchanged the floor model Baker cells with a counter top model, which is helping the work flow pattern in the outpatient dispensing area.

The pharmacy has received $10,338.95 worth of pharmaceuticals in exchange for outdated and/or overstocked products.

As of March 31, 1983, $27,571.35 has been spent for direct issue items. Stores expenditures were $47,435.60 for the fiscal year through March 1983.

Ft. Yuma (John Young)

Daniel Williams was appointed Quality Assurance Coordinator for the Service Unit. Pharmacy is now represented at daily chart rounds, monthly Medical Care Evaluation Committee meetings, and Infection Control meetings.

Outpatient workload continued to increase. Prescriptions increased 18% compared to last quarter. Pharmacy, as primary provider, continued at 20% of all outpatient visits.

Whiteriver (Steven Garrett)

Steve Garrett, Jerry Phillips, Roger McGhee and Tony Zelonis attended the Advanced Cardiac Life Support course January 14-16, 1983. During the past year, eight pharmacists in the Whiteriver Service Unit have been A.C.L.S. certified. In addition, Steve Foster was certified as an A.C.L.S. instructor.

Several "Sudden Infant Deaths" have occurred in the Whiteriver Service Unit during the past quarter. Based on our population, the incidence of SID's here is considerably higher than the national rate. As a result of the high rate, considerable effort was expended to educate both patient population and hospital staff on SID's.

PORTLAND AREA

Area Highlights

Portland (Jere Toomey)

In the clinics, 34.8% of the patients seen were instances in which the pharmacist was the primary provider by APC definition. This is a 6.4% increase over last fiscal year and an 18% increase since the end of FY 1981. Chemawa was highest with 45% followed by Fort Hall, Northern Idaho and Yakima each with 42%, Northwest Washington with 37% and Yellowhawk at 35%. Others ranged between 25% - 29% except for Colville at 15%.

The average number of prescriptions per OPV seems to be continuing its upward trend. Several years ago it seemed to remain flat at about 1.0 prescriptions per OPV, but in the past three to four years it has gradually increased. In FY 1983, it was 1.29 prescriptions per OPV.

The total workload increased 11.2% over FY 1982 even though OPV's increased only 5.0% during the same period. This increase is almost totally accounted for in the increased number of prescriptions filled and primary care visits. Taholah was the only Service Unit with a significant decrease in workload (10%).

Contract Care Costs - the cost per CHS prescriptions rose 7.2% this fiscal year, from $11.06 to $11.86. The number of CHS prescriptions filled appears to be higher this year than last fiscal year, however much of this is due to the fact that we have better reporting this year since implementing the CHS Pharmacy Reporting System.

Yellowhawk (Allan Jio)

An audit of contract health prescriptions was completed during the quarter. The main area of interest was to find how many prescriptions for chronic medications were being filled on contract that could be obtained here. Other areas of interest were reviewed for purposes of gathering baseline information. Actions taken from the audit findings include the addition of a number of medications to the Yellowhawk formulary to allow prescriptions for previously unavailable medications to be obtained here at a significant price savings.

Chronic medications being filled on contract at local pharmacies will become an ongoing monthly activity and be reported through the P & T committee.

An hour and a half presentation was given to the residents of the Tribal Halfway house on the effects of alcohol and its interactions with other medications.

The total number of prescriptions dispensed for FY 1983 were 17,282, a 12% increase over FY 1982. Total workload units for FY 1983 were 24,530, a 15% increase over FY 1982.

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Yakima (Gary Nelson)

We have experienced another busy year at our health center. The pharmacy workload increased again by about 3% over last year. We have almost doubled the number of prepackaged medications since last fiscal year.

The pharmacy continues to work closely with the home health program for the elderly on the reservation. The more involved you get with the elderly the more work you find to do. We continue to supply medications to a nursing home, alcohol detoxification center, White Swan Health Center and three outreach well child clinics.

This past spring, Gary Nelson gave two presentations. One was a discussion on OTC Drug-Drug Interactions before an audience that was attending a tribally sponsored health fair. Also, a talk was given to a group of CHR's on geriatric drug therapy.

Michael Ball attended the Area Pharmacy Officers conference in June held in conjunction with the CCEC planned seminar.

Lummi (David Elder)

Projects for the upcoming fiscal year include revising the standing orders for pharmacist practitioner care, and developing protocols for the pharmacy department for monitoring chronic medication patients. We also hope to start using a chronic medication profile sheet.

Chemawa (Alex Jones)

Statistically the 4th quarter workload units and prescriptions filled were essentially unchanged from the 4th quarter of FY 1982. As was noted with the previous quarterly report, the substantial rate of growth noted in the last year or two seems to have leveled off. For FY 1983 as a whole, we experienced an approximate increase of 2,000 workload units over FY 1982. Based on the total outpatient clinic visits, the pharmacist practitioner continues to see approximately 15% of all OPV's.

Colville (Norman Harrington)

The pharmacy is trying very hard along with the remainder of the clinic to generate APC's for each refill. Often the doctors will give orders or the chart will arrive in the pharmacy without an APC. New imprinters have been ordered, the cards are being updated to reduce our error rate and new cards are being made so that APC's don't have to be hand-written. It's surprising how much more willing patients will talk and ask questions now that my consultation room has a sit-down type counter.

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Northern Idaho (Steven Doane)

The fourth quarter of FY 1983 saw a 5.7% increase in prescriptions dispensed (3,391) over FY 1982 (3,209). This increasing trend will probably continue now that the winter months are approaching. For the entire FY 1983 year there was a slight increase over FY 1982 in prescriptions dispensed from 14,061 to 14,092. Therefore, workload did not appreciably change this year in the direct provision of medications.

The area of greatest concern and workload change came in provision of medication supplies to the Kamiah and Plummer Satellite Clinics. FY 1983 saw a 37.4% increase over 1982 for satellite issues. A recent time study showed that 9-10 hours was required to complete each order, with 55% of this time taken for prepack label typing alone. This once again emphasizes the pressing need for word processing/label producing capabilities and possibly additional help at this Service Unit. Due to the increased workload, already scarce professional time is increasingly used for clerical duties.

Overall prescribing habits have not significantly changed over the past year with the issuance of 1.8 prescriptions per patient. There was a total of 1,856 patients seen in the pharmacy for prescriptions and an average of 53.4 prescriptions per day dispensed this quarter.

NASHVILLE AREA

Area Highlights

Cherokee (Jim Mills)

The workload was expected to decrease some this year with a new ruling that eliminated services to white spouses. But records show: an increase of 1,600 new prescriptions, an increase in IV additives, a slight decrease in unit dose issues, and a slight decrease in Florida issues. Overall there was an increase of 1,721 workload units.

Our pharmacists spend a great deal of time consulting with our physicians. This is a rewarding experience as it gives us an opportunity to be a part of the team in service to those patients receiving care here at the facility. Our IOWA Drug Information Center really is an asset in securing information needed by the physicians for patient care.

Beginning next quarter we will receive the services of a pharmacy practitioner about 40% of the time as a pharmacist.

We have had one pharmacist do a home study course through correspondence and all pharmacists go to Ashville and spend two days with MAHEC program, making rounds with physicians and learning some new techniques that have proved beneficial to patient care. This has been a free program for us but also very valuable to see procedures performed in another hospital.

Mr. Mills attended the Area Pharmacy Officers meeting in Rockville and one pharmacist went to a workshop in Chapel Hill for antibiotic training.

Again this year we participated with the University of North Carolina by having a pharmacy preceptor program for senior students from UNC School of Pharmacy. We have enjoyed having the students and feel it is a very worth while program as it requires the pharmacist to keep abreast of current changes and teaches the students in a variety of situations.

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Philadelphia (John Peebles)

During the fourth quarter, we have had a full complement of physicians on duty at the hospital and, as a result, it has been quite busy in the pharmacy department. Statistically, the inpatient workload census shows that there were 278 patients admitted to the hospital during the fourth quarter. Pharmacy inpatient services include 17,997 unit dose issues, 2,565 IV admixtures and sterile reconstitutions, and 372 stock containers issued to the medical ward. The outpatient workload census reveals that there were 6,660 outpatient visits with the pharmacy department filling 8,156 prescriptions for these patients. There was an additional 962 medication items dispensed to patients coming to the pharmacy for OTC medications and/or refills of medications. There were also 2,836 stock containers issued for outpatient services. The field clinics are staying quite busy as evidenced by a total of 8,144 issues to the clinics during the fourth quarter. The pharmacy is awaiting receipt of drugs ordered from various vendors which were purchased from year-end funds to help build up the inventory in the supply room. The pharmacy submitted requisitions totaling approximately $50,000 and include both line items and direct issue items. It will certainly be an asset if all of these drug items can be received to build up our inventory and start the new fiscal year under favorable conditions.

There were two antibiotic sensitivity studies conducted during the quarter and information gathered from the studies was submitted to the Infection Control Committee. The studies show that bacteria commonly encountered here at this hospital are still quite sensitive to the older, more-commonly used antibiotics even though the medical staff quite frequently prescribe a new, more expensive antibiotic whenever another less expensive antibiotic could be used for proper results.

There were 2 drug allergies and 8 drug ingestions reported during this quarter. Two of the drug ingestions were accidental (children) while six were considered "suicidal" gestures. Drug sensitivity cards were filled out for the drug allergies and ingestion cards were filled out for the drug ingestions. This information will be sent in to the FDA for reporting purposes.

TUCSON AREA

Area Highlights

San Xavier (James Myers)

Pharmacy objectives for the coming year include:

- To assure that drug treatment plans included in patient treatment plans are appropriate.

- To provide patient assessment and treatment services, including the collection and documentation of subjective and objective data, for ambulatory patients with selected acute and chronic illnesses within the needs of the Service Unit's program for delivering primary health care.

- To promote the safe and effective use, including compliance, of the prescribed medications by the patient in the home.

- To provide dispensing, distribution, drug preparation, drug information, patient counseling and education, staff consultation, and inservice educational services.

- To assure that pharmaceutical products are available and accessible when and where needed, and that they conform to standards of quality for potency, purity and efficacy at the time they are administered to or used by the patient.

The pharmacist at San Xavier saw 23+% of the patients presenting for primary care.

Sells (Frank Dodge)

Pharmacy's information efforts have centered around two activities during the fourth quarter for 1983:

a) As an ongoing practice, all outpatients are routinely instructed in the proper use and storage of their medications, with emphasis on the importance of compliance, finishing an entire course of antibiotics and proper storage of various drugs.

b) Efforts are continuing to explain the Hospital's policy on refills to patients and CHR's. Since the Pharmacy is not authorized to refill for periods other than those specified by the prescriber, each pharmacist is attempting to educate the patients and CHR's as to the importance of keeping appointments. Particular attention is given to our diabetic and hypertensive patients.

c) A "Request for Medication Refill" form has been developed and will soon be implemented to assist the patient in the refill program.

Sister Francis Ann continued working as a volunteer in the Pharmacy Department during the quarter. Her helpful assistance has allowed the Pharmacy Department to increase its prepacking and prelabeling of many pharmaceuticals. In addition, helping to expedite the filling of prescriptions in the outpatient pharmacy, the availability of a greater number of drugs in prepackaged and/or prelabeled containers, will also assist the outpatient department.

During the third quarter of 1983, the pharmacy expended approximately $60,000 on direct issue and stores inventory. A sustained effort to obtain credit for outdated, deleted and/or damaged drugs, resulted in a savings of over $34,000 since the beginning of the fiscal year. A savings of over $6,000 was achieved in the third quarter. The Director, Pharmacy, will continue to review all orders to ensure that loss is held to an absolute minimum and that quantities ordered are sufficient, economical, and timely.

Walter Moore, Quality Assurance Coordinator for the Sells Hospital, participated in monthly meetings of the Quality Assurance Committee.

Frank Dodge has been attending a series of meetings related to the identification of computer needs and selection of an automated pharmacy system.

The Isolated Hardship Service Ribbon was awarded to Frank A. Dodge and Michael W. Woodford.

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MINUTES

OF THE

INDIAN HEALTH SERVICE

AREA PHARMACY OFFICERS' CONFERENCE

Rockville, Maryland

September 12 - 15, 1983

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INDIAN HEALTH SERVICE
AREA PHARMACY OFFICERS' CONFERENCE

Rockville, Maryland
September 12 - 15, 1983

ATTENDEES:

Charles U. Erdeljon
Acting Chief, Pharmacy Branch
Headquarters

Theodore A. Westley
Chief, Area Pharmacy Branch
Aberdeen Area

Theodore B. Pukas
Deputy Chief, Area Pharmacy Branch
Aberdeen Area

Emil L. Cekada
Chief, Area Pharmacy Branch
Alaska Native Health Service

Timothy F. Svoboda
Chief, Area Pharmacy Branch
Bemidji Area

Richard M. Church
Chief, Area Pharmacy Branch
Oklahoma Area

Richard N. Herrier
Chief, Area Pharmacy Branch
Phoenix Area

Jeremiah R. Toomey
Chief, Area Pharmacy Branch
Portland Area

Eugene B. Smith
Chief, Area Pharmacy Branch
Navajo Area

James E. Mills
Chief, Area Pharmacy Services
Nashville Area

James C. Yatsco
Area Pharmacy Consultant
Albuquerque Area

James C. Myers
Chief, Area Pharmacy Branch
Tucson Area

Joseph H. Deffenbaugh, Jr.
Special Project Officer/Pharmacist
Nashville Area

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AREA PHARMACY OFFICERS' CONFERENCE

Parklawn Building
Conference Room L, Third Floor
Rockville, Maryland
September 12 - 15, 1983

September 13, 1983

8:30 AM	The IHS Pharmacy Branch	Mr. C. Erdeljon
9:00 AM	The Indian Health Service Today	Dr. J. Todd
10:00 AM	CPOD Issues: New Billieting System, COEPR, Staffing, Performance Appraisal	CPOD Staff
12:00 AM	Lunch	
1:00 PM	CPOD Issues: Continued	
2:00 PM	Pharmacy Staffing in the IHS	Dr. R. Church
3:00 PM	Break	
3:20 PM	Pharmacy Workload Reporting and Productivity Measurement	Dr. R. Church
5:00 PM	Adjournment	

September 14, 1983

8:00 AM	Pharmacy Staffing Issues (Cont'd)	
9:00 AM	Overview of the ASHP Professional Services Division Residency Accreditation Program Hospital Pharmacy Management Information System (HPMIS)	 Dr. M. Ray Dr. M. Stolar
12:00 AM	Lunch	
1:30 PM	Acting Director, Office of Health Affairs Food and Drug Administration	Dr. M. Haffner
3:00 PM	Break	
3:15 PM	The IHS Clinical Pharmacy Project Evaluation Future Direction for the Clinical Support Center	Mr. G. Copeland
4:00 PM	Merit Promotion Plan - "Knowledge, Skills & Abilities" for Pharmacists	Mr. J. Toomey
5:00 PM	Adjournment	

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September 15, 1983

8:30 AM	Pharmacy Staffing (Cont'd)	Dr. R. Church
10:00 AM	IHS Information System Plan Implications for Pharmacy Branch	Mr. T. Westley
11:00 AM	Patient Consultation Services in the Indian Health Service	Mr. T. Svoboda
12:00 AM	Lunch	
1:00 PM	Other Topics:	Group Discussion
	New Pharmacist Orientation	Dr. E. Smith
	Equity Health Care Update	Mr. T. Svoboda
	Non-Pharmacist Dispensing	Mr. T. Pukas
	Area Pharmacy Meetings	Group Discussion
	Area Warehouse Update	
	Recruitment	Mr. C. Erdeljon
	437 Student Placement	Mr. C. Erdeljon
	IHS Pharmacy Residency Program Update	Dr. E. Smith
	Specialized Pharmacy Consultation Details Update	Mr. J. Yatsco
	Medication Profile Forms	Dr. R. Herrier
4:00 PM	Review of Recommendations	Dr. R. Church
	Assignment of Projects	
	Summation of Conference	Mr. C. Erdeljon
5:00 PM	Adjournment	

IHS AREA PHARMACY OFFICERS CONFERENCE

ROCKVILLE, MARYLAND

September 13 - 15, 1983

Monday - September 12, 1983:

Tour of the Clinical Center, National Institutes of Health

On September 12, a group of the IHS Area Pharmacy Officers arrived early in order to take a tour of the Clinical Center. Dr. Joe Gallelli and Mr. Frank Barletta conducted a tour of the facility. The tour was very interesting. This added activity provided the participants with the opportunity to visit another facility while in the Washington, D.C. area. In past years, the meeting agendas have not allowed time during the meeting schedule to visit other locations.

We appreciate the opportunity to visit the Clinical Center and wish to thank Dr. Gallelli and Mr. Barletta for taking the time to showing us their program.

Tuesday - September 13, 1983:

Attendance: James Mills, USET; Eugene Smith, Navajo; Rick Herrier, Phoenix; James Myers, Tucson; James Yatsco, Albuquerque; Richard Church, Oklahoma City; Jerry Toomey, Portland; Tim Svoboda, Bemidji; Emil Cekada, Alaska; Joe Deffenbaugh, USET; Ted Pukas, Aberdeen; Ted Westley, Aberdeen; and Charles Erdeljon, Rockville. The meeting chairman was Richard Church.

Mr. Charles Erdeljon, Acting Chief, IHS Pharmacy Branch

Opening remarks were made by Mr. Charles Erdeljon. The past year has been very interesting and has presented many challenges.

1. The RRM staffing criteria for pharmacy has been questioned by HRSA. This is based on a study that compares the staffing of selected IHS facilities with other federal agencies and other staffing indicators, (Appendix L). It is important for us to document activities and point out where and how often pharmacists are employed in field clinics. If the RRM document is not acceptable to us as IHS pharmacists, a thorough review should be made and an acceptable revision should be submitted for consideration.

2. Several changes in responsibility have been made at IHS Headquarters. Dr. Rhoades has become much more deeply involved in the budget and with Congress. ASG John Todd is now the Acting Deputy Director of the IHS and as such has assumed most of the day to day management responsibilities in directing the IHS.

3. The last reorganization of the Public Health Service left the IHS as the major portion of HRSA. HRSA has therefore devoted a considerable amount of time and effort to studying the IHS. They have challenged the IHS at virtually all levels of management. The present Corps strength is about 5600. HRSA has 3300 officers, of which 2560 are assigned to the IHS. Surgeon General Koop is totally committed to the PHS and the Commissioned Corps. There has been some discussion on moving IHS out from HRSA to become an agency or elevate IHS to the Assistant Secretary level.

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The Pharmacy Branch Annual Report for FY82 has only recently been released. Many questions are coming in about the report - especially about the discontinuation of non-prescription medications.

5. Mr. Erdeljon discussed selected documents that were distributed during the past year. Circular 81-9 entitled "Compliance Standards with the Joint Commission on Accreditation of Hospitals and Health Care Financing Administration" outlines duties of the Area Directors and Service Unit Directors, (Appendix A). It also discusses program services and professional activities. This document was originally prepared while Dr. Johnson was Director of the IHS but it was never fully implemented. IHAD's and SUD's objectives are being set based on this document. An update of the circular is being prepared that will set Circular 81-9 in place.

6. HSA-91 is still sufficent for our purposes of collecting workload data. We may add or delete categories from this form, but it is recommended that no workload unit changes be made at this time.

7. The Food and Drug Administration wants to become involved in International Health. The U.S. Agency for International Development (USAID) is also interested in providing health support to developing countries. The involvement of IHS pharmacists as technical consultants to developing countries (The Gambia) has attracted a considerable amount of attention. Dr. Brandt favors continued involvement in these activities but feels that other agencies, such as USAID, should provide salary support. The issue of who provides salary support has not yet been resolved.

8. The Commissioned Corps continued to be studied and discussed. Secretary Heckler has stated her support for the Corps. Adding to the importance of maintaining the Corps is a military statement that the PHS is responsible for health care during national disasters.

Dr. John Todd, Acting Deputy Director, IHS

1. Dr. Todd described some recent staff changes. Dr. Rhoades informed the IHAD's of major changes in the Headquarters office about three weeks ago. Dr. Todd is Acting Chief of Staff. Dr. James Felsen continues as Chief Medical Officer with added responsibility for the Division of Program Operations.

   A search committee has been appointed to find a Deputy Director for the IHS. Eleanore Robertson, Aberdeen IHAD is the chairperson of this committee. The deputy position has been advertised.

2. Performance Appraisal Standards (PAS) are a priority item of both HRSA and IHS.

3. Fiscal year 1983 was another financial disaster. The IHS needed RIF authority or would have been virtually shut down. There was a series of oversight hearings held regarding the IHS. Senator Goldwater wrote a very emphatic letter to the President addressing the health needs of the Indian people. After being told all year that absolutely no supplemental appropriation would be made, the IHS did receive a supplemental appropriation and also pay act monies for FY-83. It would have been nicer to have received the supplemental earlier in the year so that the program could have been managed better. It is felt that a supplemental will be built into the FY-84 budget, increasing IHS funding about $100 million. The FY-81 base is being used as a guide.

4. Continuing education and training is recognized as important and has been identified as a potential priority. Funding will be reserved for its provision.

5. Several significant equipment items have been purchased during the past year by IHS including between 16-18 ambulances. The Alaska Native Medical Center in Anchorage received a CT scanner.

6. The Indian Health Care Improvement Act is up for reauthorization next year.

7. There has been much talk about the Contract Health Service Task Force. The findings of the Task Force has generaged a lot of discussion.

8. In the coming year, more time will be spent by Headquarters in operation and management of the IHS in the field. Area reviews are being reinstituted. We need to continue to look at the quality of health care we provide. During the past year, most of the time has been spent responding to HRSA inquiries. The Department of Program Operations has been heavily involved with work assignments on other projects.

9. There are still no answers on the future of ORD, CCEC and Headquarters West. There will be a reorganization of Headquarters in 1984. IHS will also look at consolidating Area/Program offices. IHS will change, but remain a great program.

Commissioned Personnel Operations Division (CPOD Staff)

1. CPOD Reorganization - D. Bertin (443-4590)

   CPOD was reorganized a few months ago. The new structure has been outlined in a recent Commissioned Corps newsletter.

2. Revised Billet Program - Gloria Ames (443-2618)

   OPM charged CPOD to run a pilot project on a new billeting system. The original idea was to standardize billets for CO's in typical positions and establish benchmark billets.

   Gloria Ames is responsible for the billet pilot project. Under the new system, the supervisor or line manager will write and rate billets before sending them to CPOD. Standardized billets will be encouraged. There appears to be a shift in emphasis from the person to position. The pilot study will probably create a great deal of confusion. Both IHS and the Pharmacy Career Development Committee (Appendix B) are opposed to decentralized rating of billets.

   The benchmark billets are satisfactory for supervisory personnel, however it is felt that persons involved in clinical areas will not be rated commensurately with responsibility. With this in mind, it is necessary to establish additional clinical benchmark billets and change the rating factors to account for the importance of patient care. It is advisable not to make the benchmarks too complex.

   The 0-6 billet requires a rating of 2500. The old system of rating a Deputy Chief at 90% of the Chief is no longer valid.

   The rating factors have been set and are based on a factor evaluation system. It is advisable to read the present benchmark billets (Appendix C) and send in written comments to the IHS Pharmacy Branch during the trial period. The comments received will be gathered and distributed to all Branch Chiefs.

Recommendation: The Area Pharmacy Officers will study current billets and develop representative or "benchmark" billets for a representative group of pharmacy positions.

The following task force was appointed:
Jerry Toomey, Portland Area, Chairman
Rick Herrier, Phoenix Area (Clinical Pharmacist Billet)
Jim Mills, USET

Copies of billets developed and/or revised will be forwarded to Mr. Erdeljon by November 1, 1983 for distribution to all Areas.

3. Qualifications Profile - R. Taffett

There were questions about the Qualifications Profile received by all officers. The development of the profile relates to a management objective for current information on pharmacy officers. This profile was supposed to serve as a minor substitute for a CV, but a CV is still superior. The current profile is based on self identification of areas where individuals feel the most "comfortable" professionally. The profile will be developed and refined over time.

Recommendation: Each Area Pharmacy Officer should encourage every pharmacist in his Area to submit an updated CV for his Official Personnel File. These should be submitted to CPOD through Mr. Erdeljon's office.

4. Regular Corps Assimilation - R. Taffett (Appendix D)

The status of assimilation has not changed much over the last several months. Of the 280 officers in the 1980 group now approved for assimilation, 39 are pharmacists. More than 600 officers in the 1981 and 1982 groups requesting assimilation have been rank ordered by specialty. The working ceiling for the Regular Corps is 2500, even though Congress has set the limit at 2800. Physicians and nurses are under-represented in the Regular Corps thus priority has been given to these catagories. A nomination list including 19 pharmacists from 81-82 has been prepared. This list is not out of the office yet. About one out of three pharmacists applying are now recommended for assimilation. The 38-40 pharmacists' names not recommended at this time will be placed back into the hopper again for reranking with new applicants. Without an increase in Regular Corps ceiling to 2800, new assimilations will be made only through attrition or retirement once the working ceiling of 2500 is reached.

CPOD is now acknowledging receipt of assimilation applications. If one leaves active duty, one must reapply for assimilation upon reactivation. The three year probationary period starts from the date of reactivation. Applications can be made at any time but no action will be taken until the probationary period has been completed.

5. Promotions - R. Taffett

Promotion is based on the strength of the Corps. The tone has been rather conservative. Pharmacy did quite well. Exceptional capabilities promotions have also been conservative. Nominations for exceptional abilities promotions must be tailored to the guidelines in the PHS yellow-sheets. The officer must occupy a billet rated high enough to support the grade in an exceptional capabilities promotion.

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Recruitment - R. Taffett

Recruitment of new pharmacists to the PHS has fallen on hard times over the last two years due principally to the RIS. A great deal of the applications on file are more than a year old and if physicals are not re-taken, they will no longer be acceptable and will have to be repeated. The largest problem is applicants not having current physicals.

IHS pharmacy openings are routinely advertised across the IHS but not PHS-wide. The Bureau of Prisons has about 90 commissioned officers and the staffing pattern appears stable. St. Elizabeth's might possibly experience some staffing cutbacks due to a decreased budget and no funding from the District of Columbia. The Coast Guard may add 5-6 pharmacists in FY 85.

R. Taffett stated that he will refer inquiries from pharmacists about the IHS to Mr. Erdeljon's office. They will then be referred to the specific area for follow-up.

7. Adverse Personnel Actions - B. Immerman (443-3067) Med. Branch (443-2606)

Bruce Immerman reviewed CPOD's position regarding adverse actions (Appendix E) for commissioned officers with the attendees. Probationary periods, Marginal/Substandard Performance, AWOL, and Alcohol/Substance Abuse were discussed.

Many times a failure to communicate allows problems to become worse. Management must have consistency. There is a need to have and give honest evaluations. Discipline is meant to be a constructive device.

If an officer requests treatment for drug or alcohol abuse, the PHS will provide it. PHS treatment does not mean that the officer will be retained on active duty. The Medical Branch at CPOD is the best place to seek guidance concerning substance abuse in officers.

8. Commissioned Officers' Effectiveness Reports (COER) - CPOD

Information was presented by CPOD on the development of the COERs. It was clear that the old COPR has lost its usefullness due to the evolution of highly inflated rating factors. In reality, the life expectancy of an efficiency/effectiveness rating document should not exceed four to five years. If used beyond this time period, they no longer remain non-biased and soon the rating factors become highly inflated. Mention was made that while performance appraisal standards may be used as a tool in determining effectiveness ratings, they will not be made part of the officer's personnel file.

A letter will be coming out instructing COERs raters within the IHS to forward a completed COERs to the Headquarters Branch Chief, (Appendix F). Hopefully this will be forwarded through the Area Branch Chiefs, but Dr. Rhoades is leaving this decision in local Area Director's hands.

Recommended Action: A copy of each IHS pharmacy officer's COER should be made and routed through program channels for comments by the Area and Headquarters Pharmacy Branch Chief. The Area Pharmacy Branch Chief should be aware of the evaluation of their pharmacy officers and have the opportunity to make comments (positive or negative) if appropriate.

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American Society of Hospital Pharmacists (ASHP)
Professional Services Division Overview - Dr. Michael Stolar (Appendix G)

Dr. Michael Stolar, Director Professional and Research Services, ASHP, presented the overview. Emphasis was on a soon-to-be published report of a national pilot-test of an experimental hospital pharmacy work measurement productivity system known as the Hospital Pharmacy Management Information System (HPMIS). Discussed were prior work measurement system (eg, American Hospital Association's Monitrend System) and the problems associated with the use of these systems. The old systems failed to capture changes in the professional practices of pharmacy especially those dealing with clinical pharmacy activities or to quantify administrative/management tasks or outputs. The pilot test project points out that one-third of TOTAL staff time is devoted to administrative activities. HPMIS is being proposed as a national system. This system will address costs, products and services. Times will be broken down by pharmacist and supportive staff and by administration management, clinical services and product costs. The major problem inherent in a national work management system is that in order to make it usable for all individuals, the system becomes excessively detailed. The more detailed or more complicated the system, the more time it takes to complete. This ASHP project ties in with the IHS pharmacy RRM staffing criteria and the committee working on that project will maintain liaison with the ASHP.

Conclusion: A work measurement system should not be used to make interhospital comparisons but may be used to compare trends within the same system.

ASHP Pharmacy Residency Programs and Accreditation - Dr. Max Ray (Appendix H).

Dr. Max Ray, ASHP Director of Professional Services Division presented an overview of the current and proposed ASHP recognized pharmacy residency programs and accreditation. At present there are standards and accredited pharmacy residency programs for 1) a generalist, 2) clinical pharmacy and 3) specialist (nuclear pharmacy, psychopharmacy, nutritional support or drug information). Standards for pharmacy residencies in the following areas have been developed but at present there are no accredited programs (ambulatory, pediatric, geriatric and oncology). In the planning stage is a residency at an advanced level of hospital pharmacy administration. The process of obtaining accreditation for a pharmacy residency was presented and can be obtained from ASHP. Applications will be considered from any hospital or corporate entity (as long as the corporate entity is an organized health care entity). The interest of the group centered around the standards for residencies in ambulatory care and clinical pharmacy. It was pointed out that IHS already has established credibility in academic and professional pharmacy circles regarding ambulatory care pharmacy programs and activities. IHS pharmacy services stress the role of the pharmacist in the ambulatory care setting and preventive health. It is clear that IHS could easily play a significant role in the development of a residency in ambulatory care pharmacy.

ASHP accreditation for a pharmacy residency program will not be considered without an applicant on board. The first person through the program has no guarantee or assurance that the program will be accredited. Therefore in the development of a residency accreditation program, the requesting agency or organization needs to work closely with ASHP in order to protect both the provider and applicant. Copies of the standards for pharmacy residencies will be attached with the minutes.

Recommended Action: IHS should express interest and explore the feasibility of developing accredited ambulatory care pharmacy residency programs. Those Areas that feel they could meet accreditation standards should discuss such possibilities with their Chief Medical Officer and Area Director.

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FDA and the IHS Pharmacist's Role in the Detection of Defects in Medical Devices - Dr. Marlene Haffner

Dr. Marlene Haffner, Acting Director, Office of Health Affairs, FDA presented an overview. A medical device was defined as "anything that is not a drug, blood product, or taken inside the body." Of particular interest to the group was that the FDA has been requested to undertake a study on the safety of reusing disposable devices. The feasibility of conducting such a study is being examined.

Recommended Action: It was agreed that all IHS pharmacists should be reappraised of their role and the mechanism for the detection and reporting of defective, malfunctioning and/or poorly designed medical devices. The reporting is similar to that utilized by the pharmacists in reporting drug defects. Both are reported to the USP using the same toll free telephone line (800/638-6725). Self-adhesive instruction labels listing procedure to follow and the USP toll-free number will be distributed to all stations within IHS.

IHS Clinical Pharmacy Project Preliminary Evaluation - Mr. Gary Copeland

An update was presented by Mr. Gary Copeland, Clinical Support Center. The objective of the IHS Clinical Pharmacy Project was to move limited and diminishing resources from the pharmacist practitioner training program which was a very expensive training program given the limited number of individuals which could be trained, to a more general program which provides pharmacy continuing education specific to the needs of IHS to a broader group of individuals.

The IHS Clinical Pharmacy Project consisted of three components (newsletter, home-study course and workshops). All IHS pharmacists received the newsletter. Selected individuals or Areas participated in the home-study course and/or workshops. To be determined is which method was most effective in increasing the skills of the IHS pharmacists and cost effectiveness. The results of questionaire evaluations sent to IHS pharmacists and their Clinical Directors is now being evaluated. Preliminary results show a favorable response. Results will be presented in detail when there has been more time to analyze the statistics. These results will be reported to the Chief Medical Officers after review by the Clinical Pharmacy Project Committee and Mr. Erdeljon.

Recommended Action: Based on the results of the final evaluation, the Area Pharmacy Officers with input from field pharmacy and medical staff, will make recommendations on the direction of the IHS Clinical Pharmacy Project and future pharmacy training programs.

Patient Consultation - Group Discussion

A group discussion centered around what actually is expected of patient consultation by the pharmacist. A limited survey in the Bemidji Area (Appendix I) showed that most pharmacists felt that not every patient needs counseling beyond that which is normally part of the routine dispensing function. The survey showed that for a variety of reasons more than 50% did not receive private consultation. It was felt that a clear definition of what is meant of patient consultation and the skills and techniques required needs to be developed. Each participant was requested to send to Dick Church by September 30th, any information they have or have developed regarding patient consultation and the dispensing function. This information in turn will be disseminated to all participants for review and comment with the development of a final policy statement. Examples to be included are descriptions of what should be included in a patient consultation and how to apply the principles of non-direct counseling. Any surveys done at the service units

regarding the delivery of pharmacy services, their acceptance and effectiveness, should also be sent to Dick Church along with definitions of what is expected of a patient consultation and the skills and techniques required. It was pointed out that national attention has been raised and that the general public has mandated that they be apprised of and receive information and counseling regarding their disease entity and course of therapy. The IHS pharmacist has always been a leader in providing this information to the Indian consumer. By clearly defining what is expected of a pharmacy - patient consultation and who should receive counseling beyond the routine dispensing function, there should be no questions as to the continued commitment of the IHS pharmacist to a better educated consumer regarding the use of their medications and compliance with treatment.

The importance of patient consultation and our professional responsibilities related to it are clearly outlined in Standards of Practice for the Profession of Pharmacy in "Section III, Patient Care Functions", (Appendix J). This document should be thoroughly studied by every pharmacist. The ASHP also has published guidelines on pharmacist - conducted patient counseling, (Appendix K).

Recommendation: Reaffirm our committment to patient counsultation.

Oklahoma City Area P & T Committee - Richard Church

Dr. Richard Church made the Oklahoma City Area P & T Committee agenda and Area Drug Formulary format on WANG available to the other area pharmacy officers. Contact him if you want it transmitted electronically for use in your area. It may be reformatted to meet your specifications.

RRM Task Group on Pharmacy Staffing - Richard Church

Dr. Church read a letter from the Executive Secretary of the RRM Committee expressing concern over the staffing table and requesting the discipline re-evaluate the inpatient and outpatient staffing modules in light of the HSA manpower survey of April, 1981, (Appendix L). Over the last several months, the background material on the modules has been assembled and the Task Group appointed by Mr. Erdeljon will meet later this month to prepare a response to the RRM Committee. The task group will develop a revised staffing table for the committee. The material will be circulated within the profession for comment and some stations may be enlisted to assist in the validation studies. A response to the RRM Committee will be forwarded through Mr. Erdeljon by March 1, 1984.

Conclusion: The Area Pharmacy Officers agreed with the need to evaluate and update the staffing criteria used in the Indian Health Service in view of changes that have taken place in the practice of pharmacy. The group did not agree with some of the assumptions used in the HSA study and conclusions drawn from them, (Appendix M).

Recommended Action: The Task Group should meet as soon as possible to begin the RRM staffing revision. The items to be discussed include the updating of staffing assumptions, task list definition, projected times, comparison of management information systems, distribution of findings, and Area Pharmacy Officer and field involvement in the retesting process.

The Task Group members are:

Richard Church, Oklahoma City, Chairman
Bob Ashmore, Billings
Emil Cekada, Alaska
Eugene Smith, Navajo
Jim Yatsco, Albuquerque

A tentative meeting date was set for the last week in September in Santa Fe.

Management Information System Task Force - Ted Westley

Mr. Westley reported on the MIS task force activities. Systems in current use were reviewed by Mr. Westley, including the use of the optional APC field by the Aberdeen-Bemidji Area pharmacists and the computerized quarterly report designed by Mr. Westley and in use in the Aberdeen, Bemidji, Oklahoma City and Phoenix Areas. There was a discussion on projected applications of ADP technology in IHS Pharmacy practice. A sample of articles concerning computers in pharmacy was circulated from 1982 editions of the AJHP on managing computer systems. The ASHP has published the entire series in book form. This publication is highly recommended as a source of both general and specific information on computer applications in hospital pharmacy. Another information source is Computer Talk Associates (1750 Walton Road, Blue Bell, PA 19422) who publishes a "Computer Talk Directory of Pharmacy Systems 1983."

Recommended Action: A task group was appointed. The group will develop a Five Year Plan for pharmacy that can serve as a guide as individual Areas plan and implement computer applications in pharmacy practice. The committee will follow the professional literature on computer applications as it reviews potential applications. The legal requirements on computerized pharmacy record keeping will be investigated. Since it is becoming apparent that a number of facilities will be purchasing word processor equipment out of year end funds, early consideration should be given to potential applications in pharmacy.

Any proposals developed must be consistent with the Area and IHS National MIS plan.

The Task Group members appointed are:
Ted Wesley, Aberdeen Area, Chairman
Paul Vance, Albuquerque Area
Edwin Wilkerson, Oklahoma City Area

The pharmacy task group will work with the appropriate IHS representative for ADP applications depending upon final report and implementation of the MIS Task Force.

Pharmacy Residency in Gallup - Eugene Smith

Dr. Smith made a brief presentation on the status of the pharmacy residency in Gallup. The discussion related to the usefulness of residents as motivational tools for existing staff and as a way to spread the IHS pharmacy practice gospel. Dr. Smith requested that orientation materials in use throughout the IHS be made available. This should include information on the area, the Corps, the profession and cultural and sensitivity issues.

Personnel Involvement

A discussion on personnel involvement (mobility, etc) and projected shortages and staffing problems was held. It was decided that the open announcement in each area fulfilled the advertising requirements, although IHS Pharmacy Branch would make every effort to continue to make specific vacancies known throughout the IHS in a timely fashion. Mr. Erdeljon again requested that any pharmacists interested in special consultancy assignments keep a current CV on file in his office as many of those assignments come up on short notice.

Non-Pharmacist Dispensing (Appendix H)

The issue of non-RPh dispensing and physician extender prescribing was discussed. There are wide variations from state to state - this is really a gray area which will be dealt with on an individual case basis.

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Central Warehouse Operations

Continuing successes of central warehouse operations at the Navajo, Oklahoma, Alaska and Portland Areas. It was strongly suggested that any other area considering such an operation look at these (differing) models.

Patient Education/Counseling, re: Congressional Hearings (Appendix O)

A brief discussion on patient education/counseling as perceived in recent Congressional Hearings was held. Mr. Erdeljon brought down a sample packet from the FDA, additional copies are available from:

NCPIE "Get The Answers Campaign"
P. O. Box 32328
Washington, D.C. 20007

Recruitment

Program reductions in the PHS in 1981 and the existence of the recall list until early 1983 have damaged the visibility of the Corps within professional circles. Recruitment problems have become severe in the Navajo and Aberdeen Areas. Other Areas also have noted a significant decrease in the number and quality of new applicants. Remote locations within the IHS appear to account for the majority of new Corps placements and the continuation of a recruiting program to build up an applicant pool for PHS pharmacists would seem to be an IHS responsibility. The group recommends that Mr. Erdeljon, in concert with the Chief Pharmacy Officer of the PHS, evaluate the ability of current recruiting efforts to provide adequate numbers of officers for PHS/IHS purposes. The following strategies could be considered:

1. Reprinting the "Opportunities for Pharmacists" booklet in an updated version.

2. Advertising for Pharmacists for PHS assignments in the Journal of the American Society of Hospital Pharmacists and Drug Intelligence and Clinical Pharmacy.

3. Evaluate the possibility of an annual recruiting booth at the ASHP Mid-Year Clinical meeting.

4. Re-establish liaison with SAPhA Chapters and pursue COSTEP assignments as a recruiting tool.

5. Establish a modest recruiting budget within the office of the Pharmacy Branch Chief to allow IHS Area Branch Chiefs or their designees to carry on recruiting visits at selected universities.

6. Pharmacy should be specifically listed in the IHS Scholarship materials.

7. Advertise IHS vacancies PHS wide.

8. The use of Inactive Reserve Corps Officer to aid in recruiting efforts, pharmacy faculty liaison activities, etc.

The Task Group assigned include:
Mr. Erdeljon, Chairman
Ted Pukas, Aberdeen Area
Eugene Smith, Navajo Area
Tim Svoboda, Bemidji Area

Training Course: Selective Placement Factors

Mr. Yatsco and Mr. Toomey summarized a training course on selective placement factors which evidently will be required for all Branch Chiefs for their personnel duties.

Future IHS Meeting Requirements

Mr. Erdeljon reviewed the requirements Dr. Rhoades is establishing for future IHS meetings. It was decided that maximum continuing education opportunities and travel economics would be achieved by combining next years Branch Chief session with the PHS Professional Associations meeting in Phoenix in early June. Approximately 15 C.E.U.'s could be earned with ample opportunity for seeing some of the newer facilities in the Phoenix Area.

U. S. Coast Guard - Captain Vincent Fierro

The Chief Pharmacy Officer for the U. S. Coast Guard, Captain Vincent Fierro, met with us briefly. He presented an overview of the pharmacy program in the U. S. Coast Guard and potential changes in the future. He said that four - six new pharmacist positions may be available in the future depending upon the FY 85 appropriation.

It was a pleasure for us to meet Captain Fierro and we appreciate his taking time to make this nonscheduled visit with us.

GOVERNMENT PRINTING OFFICE: 1984-421-166/4373